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IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

NYSA-ILA WELFARE FUND, by its Trustees, JOHN BOWERS, ALBERT CERNADAS, FRANK LONARDO, THOMAS POPOLA, JAMES CAPO, JOSEPH N. BARBERA, BART DiMATTINA, and RICHARD H. O'NEILL,

Petitioner,

v.

FRANCIS J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; AND COLUMBUS HOSPITAL, EAST ORANGE GENERAL HOSPITAL, ST. JAMES HOSPITAL, and UNIVERSITY HOSPITAL, individually and as Class Representatives of Hospitals in the State of New Jersey; and NEW JERSEY HOSPITAL ASSOCIATION, as Class Representative of Hospitals in the State of New Jersey,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

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QUESTIONS PRESENTED FOR REVIEW

1. Does the Employee Retirement Income Security Act ("ERISA") pre-empt a state healthcare statute that (i) deliberately shifts onto ERISA plans the cost of care provided to persons not covered by the plans and the cost of rate discounts provided to preferred insurers, (ii) increases the costs incurred by ERISA plans for hospital services to their beneficiaries by more than one-third, (iii) cannot function without the enforced participation of ERISA plans, and (iv) by express reference to ERISA plan beneficiaries deprives them of appeal rights enjoyed by others?

2. Does a state healthcare system that requires certain private welfare plans to pay for the hospital costs of the indigent and for mandatory discounts to certain favored insurers constitute a taking of private property without compensation in violation of the Fifth Amendment to the Constitution of the United States where

- the system increases the plans' hospital costs by more than 33⅓%
- the only benefit received by the plans and their participants is the continued existence of hospitals in the state, which confers no special benefit beyond that enjoyed by the general public;
- in establishing and funding the plans through collective bargaining, management and labor invested in welfare plans assets available for labor costs on the expectation that the broad ERISA pre-emption clause would protect the assets from state poaching; and
- matching federal funds received by the state based upon amounts paid by the plans for the indigent are not refunded to the plans or put into the healthcare system but are deposited into the state's general treasury?

PARTIES TO THE PROCEEDINGS

All parties in the court of appeals appear in the caption of this petition except parties in other cases that were consolidated with this action. In accordance with Sup. Ct. Rule 14.1(b) the names of all parties in the consolidated cases appear in the caption of the opinion of the court of appeals, which is reproduced in the separately bound appendix to this petition. It is also noted that, pursuant to Sup. Ct. Rule 12.4, all parties to the proceeding in the court whose judgment is sought to be reviewed shall be deemed parties in this Court, unless petitioner notifies the clerk of this Court of the petitioner's belief that a party below has no interest in the outcome of the petition. Petitioner has no knowledge of any uninterested party. In accordance with Sup. Ct. Rule 29.1, petitioner states that it does not have a corporate parent, subsidiary, or affiliate.

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INTRODUCTION

The NYSA-ILA Welfare Fund ("Welfare Fund") and other employee welfare benefit plans protected by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §§ 1001-1461 (1988 & Supp. IV 1992), became the targets of a deliberate scheme

by the State of New Jersey to force these plans to do that which ERISA prohibits: use their funds for the benefit of persons who are not plan beneficiaries. Under the guise of a neutral law of general application fixing hospital rates the State of New Jersey actually adopted and implemented an elaborate cost-shifting scheme under which ERISA plans and their beneficiaries were forced by state law to use plan assets to finance the cost of hospital care provided to the indigent and to subsidize discounts provided to certain preferred insurers. The district court concluded that ERISA pre-empted application of this cost-shifting scheme. Despite the magnitude of the cost-shifts and their use to defray expenses of state programs from which ERISA plans and their beneficiaries derived no special benefit, the district court held that the cost-shifts were not a taking violative of the Fifth Amendment to the Constitution of the United States. A divided panel of the court of appeals reversed the pre-emption ruling and affirmed the Taking Clause determination. The Welfare Fund urges this Court to review the circuit court's decision.

OPINIONS BELOW

The judgment and opinion of the court of appeals, which is unofficially reported at 61 U.S.L.W. 2723 (3d Cir. May 14, 1993), are reproduced in the separately bound appendix to this petition (1a-61a).[1] The unreported opinion and order of the court of appeals sur petition for rehearing *en banc* (62a-63a) and the opinion and order of the United States District Court for the District of New Jersey (64a-95a), which is reported at 793 F. Supp. 524 (D.N.J. 1992), are also reproduced in the appendix.

JURISDICTION

The judgment of the court of appeals was entered on May 14, 1993. Thereafter the court of appeals denied a petition for rehearing by order dated June 15, 1993. This petition is filed within 90 days of both dates. The jurisdiction of this Court is invoked pursuant to 28 U.S.C. § 1254(1) (1988).

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[1] References are to the pages of the appendix.

CONSTITUTIONAL PROVISION AND STATUTE INVOLVED

1. The Fifth Amendment to the Constitution of the United States provides in relevant part:

> nor shall private property be taken for public use, without just compensation.

2. The relevant statutory provision is ERISA § 514(a), 29 U.S.C. § 1144(a) (1988):

> **(a) Supersedure; effective date.**
>
> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

STATEMENT OF THE CASE

A. Employee Retirement Income Security Act

In 1974 Congress enacted ERISA, a comprehensive regime to protect the interests of employees and their beneficiaries in employee benefit plans. ERISA's "crowning achievement" was the elimination of state regulation of employee benefit plans. *See Shaw v. Delta Air Lines,* 463 U.S. 85, 100 (1983). Congress fostered this objective by enacting a broadly worded pre-emption clause, ERISA § 514(a), which provides that ERISA "shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA. 29 U.S.C. § 1144(a) (1988). Lest there be any doubt, Congress also broadly defined the term "state law" to include all laws, decisions, rules, regulations, or other state action having the effect of law and the term "state" to include any political subdivision, agency, or instrumentality. 29 U.S.C. §§ 1144(c)(1), 1144(c)(2) (1988).

The function of federal pre-emption is to give effect to the "full purposes and objectives" of federal legislation, *see Hines v. Davidowitz,* 312 U.S. 52, 67-68 (1941), since under the Supremacy Clause of the Constitution of the United States federal law is "the supreme Law of the Land" to which "any Thing in the Constitution or Laws of any State to the Contrary" must yield. U.S. CONST. art. VI, cl. 2. When Congress adopts a broadly worded pre-emption provision, the "task of discerning congressional intent is considerably simplified." *Ingersoll-Rand Co. v. McClendon,* 498 U.S. 133, 138 (1990).

Previous decisions of this Court have described ERISA's express pre-emption provision as "conspicuous for its breadth," *FMC Corp. v. Holliday,* 498 U.S. 52, 58 (1990), "virtually unique," *Franchise Tax Board v. Construction Laborers Vacation Trust,* 463 U.S. 1, 25 n.26 (1983), and "designed to establish pension plan regulation as exclusively a federal concern." *Ingersoll-Rand,* 498 U.S at 138. The clear and unambiguous congressional intent of expansive pre-emption is manifested not only in the explicit language of ERISA's pre-emption clause itself but in the historical record of its legislative passage.

> The bill that became ERISA originally contained a limited pre-emption clause, applicable only to state laws relating to the specific subjects covered by ERISA. The Conference Committee rejected these provisions in favor of the present language, and indicated that the section's pre-emptive scope was as broad as its language.

Shaw, 463 U.S. at 98.

ERISA's pre-emption provision has generated a wealth of decisional law, reflecting the efforts of the lower courts to plot the outer limits of ERISA's pre-emptive reach. This Court has visited the provision with unusual frequency, and it is evident from the import of its most recent decisions that it has had to do so in order to protect ERISA pre-emption from improper limits on its metes and bounds that lower federal courts have sought to impose. *See Ingersoll-Rand Co. v. McClendon,* 498 U.S. 133 (1990); *FMC Corp. v. Holliday,* 498 U.S. 52 (1990); *Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41 (1987); *Metropolitan Life Ins. Co. v. Massachusetts,* 471

U.S. 724 (1985); *Shaw v. Delta Air Lines*, 463 U.S. 85 (1983); and *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981).

The focus of these visitations has centered on the meaning and scope of the phrase "relate to," which was chosen by Congress as the controlling standard. This Court has consistently protected the ERISA pre-emption provision from erosion by lower courts' narrowing of the term "relate to." The "relate to" standard must be interpreted expansively, *see Shaw*, 463 U.S. at 98, and must be given "a broad common sense meaning," see *Ingersoll-Rand*, 498 U.S. at 139. Indeed, the controlling test for determining whether a state law meets the "relate to" standard is simple and direct: every state law that has a connection with or reference to an ERISA employee benefit plan relates to that plan and is pre-empted. *FMC Corp.*, 498 U.S. at 58-59; *Shaw*, 463 U.S. at 96-97. Pre-emption occurs even if the connection, reference, or effect is only indirect. *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. ____, 113 S. Ct. 580, 583 (1992); *Ingersoll-Rand*, 498 U.S. at 139; *Pilot Life*, 481 U.S. at 47. Only where the connection is "tenuous, remote or peripheral" is pre-emption avoided. *Shaw*, 463 U.S. at 100 n.21.

B. Facts of This Case

1. New Jersey's Hospital Rate-Setting Regime

A highly socialized system for regulating hospital rates evolved in the State of New Jersey. It had its modest beginnings in 1971, when New Jersey enacted the Health Care Facilities Planning Act, N.J. Laws 1971, ch. 136, § 18, a legislative authorization for collectivized rate-setting limited at first to patients insured by Blue Cross and Blue Shield of New Jersey (hereinafter "Blue Cross") or entitled to benefits from certain federally funded programs, like Medicare and Medicaid (20a; 66a). Seven years later the limitations were removed, and the State of New Jersey embarked on a full-fledged, comprehensive hospital rate-setting scheme that mandated fixed rates for all (66a). *See* N.J. Stat. Ann. §§ 26:2H-1—26:2H-52 (West 1987 & Supp. 1992); N.J. Admin. Code, tit. 8, ch. 31B (Supp. 1990).

2. Cost-Shifts

The State of New Jersey made a conscious and deliberate decision to impose disproportionately on ERISA plans and their

beneficiaries certain social welfare costs associated with hospital care in the state (34a; 37a; 43a). The New Jersey hospital rate-setting statute and regulations required hospitals to add to the basic rate[2] surcharges to pay for uncompensated hospital care, the "Medicare Cost-Shift," and discounts granted to certain preferred insurers. ERISA plans and their participants bore the lion's share of these surcharges (37a).

a. Uncompensated Care Surcharge

New Jersey hospitals are mandated by state law to admit every patient seeking treatment regardless of ability to pay (20a; 68a). Uncompensated care consists of costs incurred to provide hospital care to uninsured, indigent patients not covered by Medicare or Medicaid. All New Jersey hospitals were required to add to the applicable DRG rate an uncompensated care surcharge of 19% (34a; 68a), which was transmitted to the state-administered New Jersey Health Care Trust Fund, from which it was redistributed to hospitals statewide according to need (68a), *see* N.J. Stat. Ann. §§ 26:2H-18.7 18.14 (West Supp. 1992).

The uncompensated care program not only enabled New Jersey to insulate its state treasury from responsibility for indigent care but also provided the state with an ingenious windfall. New Jersey received federal matching funds for amounts collected by the Health Care Trust Fund. These federal monies, however, never found their way into the Trust Fund. They were intercepted and deposited in the general treasury of the state to be used for other purposes unrelated to healthcare.

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[2] Hospital rates were based not on the actual cost of the inpatient treatment received by the patient from the particular treating hospital but on a blended, statewide average cost normally incurred to treat the particular illness or condition (20a; 34a; 67a). An elaborate taxonomic system classified diseases into more than 740 categories, known as Diagnostic Related Groups or "DRG's," *see* N.J. Admin. Code, tit. 8, ch. 31B, § 5.3 (Supp. 1990). Each DRG for each hospital in the state was assigned a rate which was the weighted average of the cost incurred by that specific hospital and the average cost incurred by all hospitals in the state to treat that particular DRG condition (20a; 67a). The costs taken into account included both direct costs, such as salaries and fringe benefits provided to hospital employees engaged in the direct delivery of patient care, and indirect costs, such as institutional overhead expenses for management, research, education, and maintenance (41a; 67a). The DRG system itself is not at issue in the litigation (20a).

b. Medicare Cost Shift

The DRG rate was increased by an additional add-on to compensate hospitals for shortfalls caused by the Medicare Cost Shift. Hospitals treating Medicare patients received reimbursement at rates invariably less than the New Jersey DRG rates. The New Jersey Hospital Rate Setting Regulations, *see* N.J. Admin. Code, tit. 8, ch. 31B, § 3.73(a)(5) (Supp. 1990), required hospitals to include in their DRG rates billed to non-Medicare patients surcharges, averaging approximately 7% (34a), that were necessary to recoup shortfalls created by the difference between the Medicare rates of reimbursement and the New Jersey DRG rates (20a-21a; 68a).

c. Payor Discounts

Medicare was not the only preferred insurer. The State of New Jersey itself anointed others to receive "payor differentials" or rate discounts. Blue Cross was the prime beneficiary of the state's largesse, enjoying a whopping 11% discount because it offered open enrollment health insurance (21a; 68a).[3] Medicaid and Health Maintenance Organizations ("HMO's") also received favored treatment. Only commercial insurers and ERISA plans did not; indeed, they had to pay more in order to make up the shortfalls created by the privileged discounts.

3. Impact on ERISA Plans

The effect on ERISA plans and their beneficiaries of the surcharges required by the state-mandated cost-shifts was staggering. Less than 25% of the population of the State of New Jersey receives in-patient hospital care (37a). Based upon statistics supplied in the litigation by New Jersey's Assistant Commissioner of Health, the universe of hospital patients totalling approximately 1.2 million New Jersey residents each year included 900,000 non-payors whose treatment was financed by uncompensated care assessments. ERISA plan participants paid 40% of these uncompensated care costs, even though they comprised only 15% of the total hospital patient population — a substantial financial drain on ERISA plans, when annual uncompensated care costs were at the more than $700 million level and rising. The cost burden became

[3] Since federal law requires ERISA plans to limit their enrollment to covered employees and their dependents, *see infra* note 12, ERISA plans were foreclosed from eligibility for this open enrollment discount (68a-69a).

mind-boggling when the other cost-shifts were piled on, raising the tab for ERISA plans to as much as 40% of the more than $1.1 billion shortfall generated by the state-mandated cost-shifts (37a).

New Jersey's hospital rate-setting scheme was carefully fashioned not only to impose on ERISA plans and their beneficiaries the costs of uncompensated care, the Medicare shortfall, and the preferred-payor discounts but also to insure that ERISA plans could not escape the cost-shifts net. While ERISA plans were theoretically able to negotiate volume discounts with individual hospitals, no hospital in the state was willing to come to the negotiating table, since, as New Jersey's Assistant Commissioner of Health acknowledged, the New Jersey statute prohibited passing on to other patients any revenue shortfall caused by a digression from the state-mandated rates (43a). While uninsured patients were granted a right to appeal for a reduction of any excessive hospital bill whenever the DRG rates exceeded actual charges by more than $250 — an exceedingly efficacious right that resulted in a reduction to the lesser charges in 99% of the appeals (34a) — ERISA plans and their beneficiaries in a provision that expressly referred to "self-funded union [ERISA] plans" were denied this entitlement because of their plan coverage (78a).[4]

The New Jersey cost-shifting regime finally became unbearable. The average in-patient hospital benefits claim paid by Petitioner Welfare Fund in the State of New Jersey grew fourfold from $1,979.59 in 1987 to $7,990.96 in 1991. This dramatic and alarming increase could not be absorbed indefinitely out of the fixed annual level of employer contributions received by the Welfare Fund. Benefits had to be reduced, or other cost-savings realized; otherwise, the well would have run dry, and the Welfare Fund's 7,000 beneficiaries in New Jersey would have had to be added to the rolls of uninsured recipients of hospital care. Unlike other plans, which cut benefits or withheld payment of the surcharges in whole or in

[4] New Jersey's Patient Appeal Policy was classically Kafkaesque. "Self-funded union" plans were expressly ineligible to appeal (34a). ERISA plan beneficiaries also faced a no-win situation. They were ineligible if their "self-funded union [plan] does not reimburse the hospital on the DRG price per case" or if "the hospital bill has been paid in full by a third-party payer [ERISA plan] excluding the deductible." So long as a patient was an ERISA plan beneficiary, he lost his right to appeal, since he was ineligible both when his plan paid the full DRG charge and when it did not (69a). There was no other conceivable circumstance that could trigger eligibility. ERISA plans and their beneficiaries were locked in a Catch-22 bind.

part (69a), the Welfare Fund was forced to depart from its traditional self-administration system and retain the administrative services of Blue Cross. This arrangement enabled the Welfare Fund to share in the payor discount enjoyed by Blue Cross. The arrangement with Blue Cross was not limited to New Jersey. Blue Cross had to be selected to administer hospital benefits in all states in which the Welfare Fund's beneficiaries resided, since bifurcated administration would have been impracticable. Thus, apart from its devastating monetary impact, New Jersey's cost-shifting regime seriously disrupted the Welfare Fund's longstanding administrative practices not only in New Jersey but in other states as well.

C. Proceedings in the District Court

Petitioner Welfare Fund, a self-insured joint labor-management, multiemployer employee welfare benefit plan providing hospital and health benefits to longshore workers in the Port of New York and New Jersey, commenced a civil action under ERISA against two groups of defendants: the State Defendants and the Hospital Defendants.[5] The Welfare Fund sought an injunction prohibiting future enforcement by the State Defendants of the cost-shifts and also restitution from the Hospital Defendants of cost-shifts previously paid by the Welfare Fund on the grounds that the New Jersey statute was pre-empted by ERISA and worked an unconstitutional taking of property.[6] Other ERISA plans filed similar actions that were consolidated with the Welfare Fund's.

The district court entered summary judgment in favor of the Welfare Fund and the other ERISA plans on their pre-emption claim (94a). It held that the cost-shifting features of the New Jersey hospital rate-setting statute and regulations related to ERISA plans

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[5] The State Defendants were the New Jersey officials responsible for administering the challenged hospital rate-setting legislation (67a). The Hospital Defendants were virtually every acute-care hospital facility in New Jersey and their class representative, the New Jersey Hospital Association.

[6] Jurisdiction in the district court was predicated on ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3) (1988), which empowers plan fiduciaries to bring a civil action to enjoin any act or practice that violates ERISA, to enforce any provision of ERISA, or to obtain appropriate equitable relief to redress any violation of ERISA (22a). Jurisdiction to entertain ERISA § 502(a)(3) actions resides exclusively in the district courts of the United States. *See* ERISA § 502(e)(1), 29 U.S.C. § 1132(e)(1) (1988). In light of the Welfare Fund's prosecution of this ERISA action and its constitutional challenge to the New Jersey statute, the district court was also vested with subject matter jurisdiction under 28 U.S.C. § 1331 (1988), which bestows on federal district courts original federal question jurisdiction of all civil actions arising under the Constitution, law, or treaties of the United States.

and, hence, were pre-empted by ERISA because these state-mandated cost-shifts:

- forced ERISA plans to structure their benefits in a particular manner (80a);
- subjected ERISA plans to inconsistent regulation (80a-81a);
- compelled ERISA plans either to disburse funds for the benefit of non-beneficiaries in contravention of the express proscriptions of ERISA or to reduce benefits to their own beneficiaries in contravention of the express provisions of their plan instruments (81a);
- subjected ERISA plans to ongoing administrative hardship (82a); and
- contained explicit references to ERISA plans (78a).

The district court denied the Taking Clause challenge on the grounds that (1) New Jersey did not use the cost-shifts to appropriate monies for its own use, (2) the cost-shifts benefitted ERISA plan participants by assuring the fiscal viability of hospitals in the state and providing a means by which ERISA plan participants themselves could receive quality health care whenever they could not afford it, and (3) the cost-shifts did not interfere with the reasonable investment-backed expectations of ERISA plans and their participants (89a-92a).[7]

D. Proceedings in the Court of Appeals

A panel of the United States Court of Appeals for the Third Circuit in a split decision reversed the district court's grant of summary judgment on the ERISA pre-emption claim and entered judgment in favor of respondents (23a-32a; 61a). The court of appeals

[7] The district court devoted only one page of its opinion to the Welfare Fund's restitution claim (66a). Despite noting ERISA as a basis for its subject matter jurisdiction (66a), the district court nevertheless recharacterized the restitution claim not as a federal ERISA claim, as alleged in the complaint, but as a state law claim which should be deferred to the New Jersey state courts in the interest of comity. Accordingly, the district court declined to exercise jurisdiction over what it labeled a state law claim (66a).

also affirmed the district court's rejection of the Taking Clause challenge (22a-23a).

The panel refused to credit Congress's straightforward declaration that a state law is pre-empted if it relates to an ERISA plan. In the majority's view mere relationship is insufficient to trigger pre-emption. Rather, the challenged state legislation must "relate to the plans in a way that *necessitates* pre-emption" (23a) (emphasis supplied).

While paying lip service to the test set forth in the statute, the panel majority actually undermines the express congressional intent. First, in the view of the court of appeals an express reference to ERISA plans in the New Jersey legislation can be disregarded for pre-emption purposes if its removal would not alter the legal effect of the statute (25a). Second, the majority opinion finds that Congress's only intention is to pre-empt those state laws that would result in inconsistent regulation in different states, a situation the panel majority found lacking in this case (24a-25a; 27a). Third, the majority limits the reach of the conspicuously broad ERISA pre-emption clause to those specific situations where courts have already found pre-emption (25a). The majority synthesizes existing caselaw to develop principles that in effect establish boundaries beyond which pre-emption would not extend (25a-26a). In its view a state law would relate to an ERISA plan only if a prior court decision had so found.[8]

[8] On June 15, 1993, the court of appeals denied applications for rehearing *en banc* (45a-46a). On July 8 the Third Circuit granted a Fed. R. App. P. 41(b) stay pending disposition of this petition.

REASONS FOR GRANTING THE WRIT

1. This Case, Which Involves the Effect of State Healthcare Regulations on ERISA Plans, Presents Substantial and Pressing Questions of National Scope and Importance.

This case is one of exceptional significance. It involves two areas of extreme national importance, healthcare and ERISA pre-emption. The inevitable interface between these two competing desiderata gives rise to issues that cry out for prompt resolution by the nation's highest Court.

Healthcare is the subject of increasing national attention and has been called the issue of the '90's. Whatever the future may hold at the federal level, healthcare regulation similar to New Jersey's is presently the subject of legislation in 36 states, and it is likely if present economic conditions continue that other states in the union will jump on the bandwagon.[9] If the decision of the court of appeals in this case is left undisturbed, these state billing schemes will spread, laying waste ERISA plans throughout the nation.

The integrity of the national policy favoring the creation and preservation of ERISA funds is in jeopardy. Congress, prompted by a desire to preserve and protect ERISA plans and to encourage and foster their creation, formulated in ERISA the most sweeping pre-emption provision possible. The history of that provision in this Court is the highest testimony to its national significance. Ten times in the last dozen years this Court has granted certiorari to review lower court determinations concerning ERISA pre-emption.[10] In ten decisions on the merits, only thrice has the Court failed to find that the challenged state law was pre-empted. The very number of times that this Court has visited the issue underscores its national importance.

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[9] 138 CONG. REC. S13267-02 (Sept. 10, 1992).

[10] *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. ____, 113 S. Ct. 580 (1992); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990); *FMC Corp. v. Holliday*, 498 U.S. 52 (1990); *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988); *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985); *Franchise Tax Bd. v. Construction Laborers Vacation Trust*, 463 U.S. 1 (1983); *Shaw v. Delta Air Lines*, 463 U.S. 85 (1983); and *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981).

This Court has repeatedly recognized the special significance of ERISA pre-emption by relaxing the usual norms for granting writs of certiorari in cases involving this issue. Often it has departed from the usual criterion of a conflict among the circuits and has granted review under the less rigorous standard of divisions, disagreements, or conflicts among lower federal or state courts. *See Ingersoll Rand,* 498 U.S. at 137; *Mackey,* 486 U.S. at 828; *Shaw,* 463 U.S. at 95. History teaches, then, that the importance of the ERISA pre-emption issue itself and this Court's role as protector of the congressional will are sufficient reasons for granting certiorari.

That enduring importance is present in this case with a vengeance because of the healthcare context in which the threat to ERISA plans arises. Hospital rate-setting focuses on a particular area in which ERISA plans are deeply involved. Hospital care is not some ancillary service or commodity that welfare plans purchase from time to time. It is their very *raison d'être.* ERISA welfare plans exist solely for the purpose of providing healthcare to their beneficiaries.[11] ERISA welfare plans and their participants exist in every state in this nation, and the problem of healthcare, especially for the indigent, is one of national scope. There can be no doubt, then, that the resolution of the issues in this case will affect ERISA plans throughout the country.

Despite this Court's repeated recognition of the sweep of ERISA pre-emption, the court of appeals in this case purports to find a fatal chink in the protective armor that Congress created, which puts at risk the lifeblood and very existence of ERISA plans. The Third Circuit's dangerous limitation on ERISA pre-emption in a manner that clearly departs from existing precedent warrants certiorari.

The court of appeals fashioned a novel and unprecedented test concerning the manner in which a state hospital rate-setting statute can be structured to extract from ERISA funds a disproportionate share of society's healthcare costs. This test threatens ERISA funds not only in New Jersey but throughout the nation.

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[11] Section 3(1) of ERISA defines an employee welfare benefit plan as including "any plan, fund, or program . . . established or maintained by an employer . . . for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment . . . ." 29 U.S.C. § 1002(1) (1988).

The decision here will go a long way toward limiting the vulnerability of ERISA plans to the appetites of state legislatures.

The breadth of the challenge to ERISA welfare plans by state healthcare regulation and hospital rate-setting is apparent when one considers the kinds of state laws that have triggered Supreme Court review in the past. These have included state garnishment statutes, *Mackey,* 486 U.S. at 826; motor vehicle financial responsibility laws, *FMC Corp,* 498 U.S. at 53; mandatory severance pay, *Fort Halifax,* 482 U.S. at 1; human rights laws, *Shaw,* 463 U.S. at 85; tax collection statutes, *Franchise Tax Bd.,* 463 U.S. at 1; and application of state common law tort and contract actions to ERISA plans, *Ingersoll Rand,* 498 U.S. at 135; *Pilot Life,* 481 U.S. at 42. It is safe to say that few, if any, of these laws, which the court has found worthy of its consideration, have the impact on or pose the threat to ERISA plans that is implicit in state healthcare and hospital rate-regulation.

The effect of the decision of the court of appeals will not be limited to New Jersey. If left to stand, it authorizes states to establish schemes that will divert hundreds of millions of dollars annually from the intended beneficiaries of ERISA plans and to treat ERISA payors differently from other hospital payors. Under the court of appeals decision states can mandate a healthcare scheme that creates a host of exemptions for virtually everyone but ERISA plans, leaving those plans holding the bag (42a-43a). If the court of appeals is correct, a state regulatory regime can be crafted deliberately to shift onto the plans the substantial costs of others.

In this case the plans were not merely hit; they were deliberately aimed at. The effect was not only to raise costs (by better than one-third) but also to subject the plans to the Hobson's choice of either reducing benefits to their own beneficiaries or violating ERISA by expending plan assets for the benefit of strangers.[12] The

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[12] Congress adopted in ERISA the requirement that "the assets of a plan shall never inure to the benefit of any employer and shall be held for the exclusive purposes of providing benefits to participants in the plan and their beneficiaries and defraying reasonable expenses of administering the plan." 29 U.S.C. § 1103(c)(1) (Supp. IV 1992). This mandate reaffirms for all ERISA plans the identical "exclusive benefit" requirements enacted by Congress as far back as 1947 in the Taft-Hartley Act for joint labor-management plans created in collective bargaining. *See* 29 U.S.C. § 186 (Supp. IV 1992). The "exclusive benefit" provisions prohibit the use of trust assets to benefit persons other than plan participants and their beneficiaries. *In re Typo-Publishers Outside Tape Fund,* 478 F.2d 374, 375-76 (2d Cir.), *cert. denied,* 414 U.S. 1002 (1973); *Blassie v. Kroger Co.,*345 F.2d 58, 68 (8th Cir. 1965).

decision as to whether states can continue their regulation of healthcare by forcing ERISA beneficiaries, contrary to Congress's mandate, to underwrite the care of others should be made by this Court.

The district court below toppled the rate-setting scheme that had been in existence in New Jersey for more than two decades. Indeed, the program relied so heavily upon ERISA plans to pay for indigent care that New Jersey conceded that its system was not viable without this exaction from ERISA plans (37a). When the district court held the cost-shift provisions unconstitutional, it inspired the New Jersey Legislature with the approbation and encouragement of the Governor to replace the existing collectivized rate-setting scheme with a free market system that went into effect on January 1, 1993 (22a).

Repeal of the challenged state legislation did not render the issues in this case moot. Apart from the practical need to decide these issues in order to resolve the restitution claims in this case (22a; 32a), reversal by the Third Circuit permits the New Jersey Legislature to reinstate the same or similar legislation. Moreover, the final decision in this case transcends the particular statute at issue; it will establish principles that will determine the contours of ERISA pre-emption in the healthcare field nationwide. Indeed, the effect of the lower court's adjudication was not confined to the State of New Jersey alone but reverberated in the halls of Congress. Senator Durenberger introduced a bill currently under consideration to remove state hospital rate-setting programs from ERISA's preemptive sweep. S. 3223, 102d Cong., 2d Sess. (1992), *reintroduced* as S. 480, 103d Cong., 1st Sess. (Mar. 2, 1993).

However, the nation does not have the luxury of awaiting rulings from courts in other states, *see, e. g., Travelers Ins. Co. v. Cuomo,* 813 F. Supp. 996 (S.D.N.Y. 1993), *appeal pending,* No. 93-7194 (2d Cir. argued May 20, 1993), or watching the outcome of the legislative process. The immense sums involved in these state-mandated programs require a prompt ruling from this Court for the good of all concerned.

The resolution of this question will affect every sector of the nation that provides health benefits to employees and their families through ERISA plans. Under the challenged scheme in New Jersey alone ERISA plan participants, who comprised 15% of hospital patients, were required to subsidize 40% of the $1.1 billion dollar shortfall generated by the state-mandated cost-shifts (37a). This

multi-million dollar charge reflected only one year's burden. Absent immediate correction by this Court, ERISA plans will be depleted as more and more states enact varying regulations designed to leech on to ERISA trust funds.

The need for a swift and decisive ruling by this Court is great no matter how the question is ultimately decided. Hospitals operating under state regulations are presently collecting millions of dollars annually from ERISA plans, as they did in New Jersey. If the plans prevail and the state schemes are held to be unconstitutional, the hospitals will have to make restitution of these monies at least for the period of the applicable statutes of limitations. *Harper v. Virginia Dep't of Taxation,* 61 U.S.L.W. 4664 (1993) (U.S. No. 91-794). The effect upon the hospitals will be devastating. It may, indeed, require state legislatures to bail out the healthcare institutions at tremendous cost to the taxpayers. The quality of healthcare in each state cannot fail to suffer. On the other hand, if ERISA plans are not permitted to apply the unconstitutionality ruling retroactively to recover the monies unlawfully collected from them, the plans will have lost tremendous sums under laws which should never have been passed and which in our jurisprudence are considered null and void. But the money will be gone nevertheless.

Prompt resolution is also called for because until this Court finally puts the issue to rest, ERISA plans will be reluctant to make the challenged payments. Confronted with the possibility that hospitals will be financially unable to pay back monies unlawfully collected or that retroactive recovery may be denied, the plans will prefer to withhold, or escrow, those portions of their beneficiaries' bills that constitute the illegal cost-shifts. This, of course, puts a financial strain on the hospitals, can lead to the denial of services to plan beneficiaries, and engenders wasteful litigation that the resources of both ERISA plans and hospitals can ill afford. The public weal demands an end to the upheaval and uncertainty that the decisions below have created.

There is also a very practical consideration to be factored into the equation. It is clear that so long as the circuit court's decision looms over their heads, employers and employees covered by ERISA plans will not passively sit by and continue to fund medical benefits for workers merely to permit states to siphon off the monies the contracting parties believed would be held in trust. Ironically, the decision below will cause the opposite of its intended effect by inducing those employers that are already providing welfare

benefits to reduce or eliminate those benefits in favor of wages or some other form of compensation that the workers can keep, thus aggravating the underlying healthcare crisis. As their past practices attest, employers and unions favor using available assets to create and fund welfare plans. In so doing they perform a real public service, consistent with the congressional purposes embodied in ERISA of fostering and encouraging these plans. But one cannot realistically expect these plans to accept the role of wet nurse to the rest of society in a scenario that they rightly believe constitutes an unconstitutional taking of their property. *See infra* pp. 21-24.

If the Third Circuit is to be reversed, it should be done posthaste so that the contracting parties do not have to restructure their arrangements.[13] Once altered, it is unlikely that these arrangements will be changed back in the wake of some future ruling. Similarly, if the Third Circuit's position is to be upheld, simple justice requires that it be done soon, so that management and labor can order their affairs accordingly. The present state of the law is in flux, and so the great usefulness of the law as a canon pursuant to which the private sector can order its affairs is absent. Too much is at stake — $400 million in New Jersey in one year alone — to warrant delay. This Court should grant certiorari and resolve the matter as soon as possible.

2. The Decision of the Court of Appeals, with its Constriction of ERISA Pre-emption so as to Permit State Taking of Plan Assets for Public Use, Conflicts with Applicable Decisions of This Court.

The bottom line of the Third Circuit's decision is to permit state legislatures to construct healthcare and hospital rate-setting systems which mandate the use of ERISA plan assets to fund medical care for non-beneficiaries. In the view of the court of appeals the inflation of hospital costs to plan beneficiaries by a factor of more than 35% has only a tenuous, remote, or peripheral connection with the plans and is not pre-empted so long as the statutory scheme is carefully crafted to make the targeting of ERISA plans sufficiently covert.[14] To salvage the New Jersey system the Third

[13] The current longshore collective bargaining agreements on the East Coast expire on September 30, 1994. Negotiations will commence in January 1994.

[14] Statistics confirmed by the Hospital Defendants reveal that in 1991 the surcharges to finance the mandated cost-shifts amounted to more than 35% of the average New Jersey hospital bill ($2,874 of surcharges included in an average bill of $8,196).

Circuit's decision at every turn runs afoul of prior decisions of this Court concerning not only ERISA pre-emption but also the Taking Clause of the Fifth Amendment. The New Jersey law did not merely relate to ERISA plans; it did so in a way that amounted to an unconstitutional taking of their property. Review by the Supreme Court is necessary to preserve a body of ERISA pre-emption precedent that has been built up over the past 12 years to effectuate the will of Congress and to shield ERISA plans from unconstitutional takings of their assets.

A. ERISA Pre-emption

There is inherent in the opinion of the court of appeals an invidious perversion of the very essence of the ERISA pre-emption doctrine. ERISA's pre-emption clause is clear and straightforward. State law is pre-empted if it relates to an ERISA plan in the ordinary, common sense meaning of those words, — if it has a connection with or reference to an ERISA plan. *Greater Wash. Bd. of Trade,* 113 S. Ct. at 583. The wealth of litigation engendered by this clause has been due not to any ambiguity or uncertainty in the statute but to a reluctance by the lower courts to give the congressional language its plain effect, a reluctance epitomized by the Third Circuit's metaphysical quest in this case to divine some deeper kind of relating that "necessitates" pre-emption (23a). The formulation by the court of appeals would permit courts to substitute their subjective judgment for the concrete touchstone enacted by Congress.

Although it acknowledged the test set forth in the ERISA statute and repeatedly articulated by this Court, the court of appeals chipped away at the express congressional intent. In its effort to avoid a relationship "that necessitates preemption" the circuit court engaged in some fancy analytical footwork. Unmindful of this Court's admonition that "ERISA's authors clearly meant to preclude the States from avoiding through form the substance of the pre-emption provision," *Alessi,* 451 U.S. at 525, the Third Circuit transformed the "deliberately expansive" language chosen by Congress, *see Greater Wash. Bd. of Trade,* 113 S. Ct. at 583 (quoting *Pilot Life,* 481 U.S. at 46), into something crabbed and constricted.

The attorney for the state admitted that the New Jersey healthcare regime could not function without the participation of ERISA funds (35a). This candid admission was confirmed when,

in reaction to the decision of the district court that the cost-shifts could not constitutionally be imposed on ERISA plans, the New Jersey Legislature scrapped the entire system. Nevertheless, the majority of the panel of the court of appeals mischaracterized the mandated cost-shifts as a mere cost of doing business imposed by a law of general application, having too tenuous, remote, and peripheral a connection with ERISA plans to trigger pre-emption (23a; 26a-28a). The Third Circuit's error is not merely a matter of approach. Each of the bases for its decision conflicts with a prior decision of this Court.

First, the panel majority brushed aside the express reference to ERISA plans in the New Jersey legislation by asserting without any authority the proposition that the reference can be disregarded for pre-emption purposes if its removal would not alter the legal effect of the statute (25a-26a). This approach gratuitously creates an escape hatch previously unknown. This Court has never qualified its consistent holding that a statute that has a reference to an ERISA plan relates to that plan. *See Greater Wash. Bd. of Trade,* 113 S. Ct. at 583; *FMC Corp.*, 498 U.S. at 59-60; *Shaw,* 463 U.S. at 96-97.[15] Indeed, the precise argument made by the Third Circuit here, that a direct reference to ERISA plans may somehow be excused under certain circumstances and pre-emption avoided, was rejected by this Court in its latest ERISA pronouncement. *See Greater Wash. Bd. of Trade,* 113 S. Ct. at 583.

Second, the court of appeals purports to find that Congress's only intention was to pre-empt those state laws that would result in inconsistent regulation in different states, a result that declares open season upon ERISA plans that operate only in a single-state. The panel opinion quotes extensively from this Court's decision in *Fort Halifax Packing Co. v. Coyne,* 482 U.S. 1 (1987), in which that concern was mentioned (24a-25a).[16] However, to limit the congressional intent to this narrow field is manifestly unrealistic. Many ERISA plans operate only in a single state. It cannot be

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[15] Conspicuously absent from the majority decision is any analysis of the second prong of the "relate to" test. The majority does not come to grips with why the New Jersey system does not have a "connection with" ERISA plans. The dissent does not shy away from the controlling test and, applying it, easily finds the connection (37a; 39a; 43a-44a).

[16] The Supreme Court language quoted by the panel's majority is actually inapposite, since the Maine statute at issue in *Fort Halifax* called for the payment by employers of a one-time severance payment that did not implicate any ERISA plan.

seriously claimed that these single-state plans were not intended by Congress to enjoy the protections of ERISA pre-emption.

The congressional desire for uniformity must be taken as consistency *among* plans as well as *within* a plan. Congress intended that there be one, national standard governing ERISA plans and imposed pre-emption to prevent plans in one state from being treated differently from plans in another state. The Third Circuit's reading into ERISA pre-emption of a congressional purpose to thwart only inconsistent regulation of the same plan in different states is clearly contrary to the position of this Court, which has granted certiorari and found pre-emption where only single state plans were involved and inconsistent regulation was not at issue. *See Greater Wash. Bd. of Trade,* 113 S. Ct. at 588 (Stevens, J. dissenting) (dissent faults majority for pre-empting statute that poses no threat of inconsistent state regulation).

The third new limitation created by the circuit court is equally discordant with prior decisions of this Court. By developing principles that impose boundaries beyond which pre-emption will not extend, the circuit court's synthesis of existing caselaw circumscribes the conspicuously broad ERISA pre-emption clause to those specific situations where courts have already found pre-emption (25a-26a). In its view a state law would relate to an ERISA plan only if a prior court decision had so found. It is not a judicial function to erect fences where the legislature has not. Existing caselaw has hardly exhausted all the possible ways in which state statutes could relate to ERISA plans. To limit pre-emption to what has already been decided is to transform a extremely broad pre-emption provision into a very narrow one. The panel majority's approach parallels that of the Executive Branch, which had sought to define ERISA pre-emption by example or subject matter — an approach rejected by Congress. *See Shaw,* 463 U.S. at 98 n.19.

In contradistinction to the majority below the dissent stands as a model of common sense. Consistent with precedent it gives the term "relates to" its "ordinary and broad meaning"(44a). In so doing the dissent comes to the obvious conclusion that a statute which

- by express reference deprives ERISA plan beneficiaries of appeal rights enjoyed by others,
- by deliberate legislative structuring exempts a favored group of hospital payors

so as to shift their obligations onto ERISA plans,

- requires ERISA plans to devote more than one-third of their assets to fund healthcare for non-beneficiaries despite ERISA's express proscription,
- cannot function without the enforced participation of ERISA plans, and
- has quadrupled the average hospital bill for Welfare Fund beneficiaries

must relate to ERISA plans and so be pre-empted.

The majority decision which finds that a statute with these kinds of connections with ERISA plans does not relate to those plans must be tinkering with the concept of "relate to." The Third Circuit's niggardly reformation of the "relate to" test saps the pre-emption clause of all vitality in direct contradiction of consistent Supreme Court teaching. Such a radical departure should command the attention of this Court.

B. Unconstitutional Taking

No less deserving of the Court's attention is the fact that the cost-shifts mandated by the New Jersey hospital rate-setting scheme amount to an unconstitutional taking. The Taking Clause plays a significant role in this age of pervasive governmental regulation in limiting the government's power to debase the property rights and economic interests of its citizens through regulatory legislation. This Court has articulated three factors of "particular significance" in determining whether governmental regulation constitutes an invalid taking of property: (1) the character of the governmental action, (2) the economic impact of the regulation, and (3) the extent to which the regulation has interfered with investment-backed expectations. *Connolly v. Pension Benefit Guar. Corp.*, 475 U.S. 211, 224-25 (1986). The district court's analysis of these three factors (89a-92a), which was adopted by the court of appeals (22a-23a), in every respect contravenes prior decisions of this Court.

The lower courts in this case purported to see no problem because the State of New Jersey did not physically invade or permanently appropriate plan assets for its own use but merely "adjusts the benefits and burdens of economic life to promote the common good" (23a; 92a). This cavalier approach disregards the principle

established by this Court that a government regulation that goes too far will be just as violative of the Fifth Amendment as a direct taking. *Pennsylvania Coal Co. v. Mahon,* 260 U.S. 393, 415 (1922).[17]

The fundamental defect in the lower courts' analyses in this case is over-simplification of the character of the state action. That a state may never actually appropriate monies directly is inconsequential. The uncompensated care surcharges paid by ERISA plans and their participants are paid into a fund managed and controlled by a state bureaucracy. There is no doubt that the cost-shifting system is for a public use. Obviously, the State of New Jersey devised the system because of its perceived public benefit. Hospital care to the indigent and to the uninsured as well as the economic aid to the healthcare system provided by Medicare, Medicaid, Blue Cross, and HMO's presumably benefit the entire body politic.

Having established mandatory hospital care regardless of ability to pay, having compensated Blue Cross and other preferred payors for open-enrollment insurance and other systemwide benefits to the citizens of New Jersey, and having to make up the shortfalls created by the Medicare program, New Jersey had an obligation to assist the hospital industry to finance the costs of these public welfare programs. Lacking temerity to confront the public with the need for additional tax dollars to provide the state treasury with the funding required for these programs, New Jersey devised an elaborate cost-shifting scheme to have one segment of the populace underwrite the programs (35a). Under these circumstances the conclusion that there was no governmental appropriation is unrealistic and untenable.

The lower courts' analysis of the economic impact of the New Jersey system contravenes this Court's teaching that to pass muster under the Taking Clause, the state program must accord a compensatory benefit to those bearing the financial burden. *Norwood v. Baker,* 172 U.S. 269, 279 (1898) (any governmental exaction in excess of the special benefits accruing to the payor is an unconstitutional uncompensated taking). In short, there must be a

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[17] It would seem that at least with respect to part of the monies there was an actual invasion of the plans' assets. By requiring plans to pay uncompensated care taxes and then pocketing the matching federal funds, New Jersey actually took private monies for public use. The route from the plans' accounts to the state treasury may be circuitous, but it is direct, certain, and carefully plotted. Thus, despite the Third Circuit's disclaimer there is in this case a real, direct taking. With respect to all the assets the New Jersey scheme amounted to a regulatory taking, the sustaining of which by the Third Circuit contravenes prior decisions of this Court.

"reciprocity of advantage." *Meier v. Anderson*, 692 F. Supp. 546, 555 (E.D. Pa. 1988), *aff'd without op.*, 869 F.2d 590 (3d Cir. 1989).

The viability of the New Jersey hospital rate-setting scheme depended on its ability to milk ERISA plans (37a). There was no benefit to ERISA plans and their participants to compensate them for their role as public benefactors (43a). All that the district court could come up with is that the system assures the continued existence of hospitals from among which ERISA plan participants can choose and to which they can repair in the event they join the ranks of the indigent (92a). The court of appeals utterly failed to come to grips with the requirement of this Court that the benefit must be discrete and particular to the victim of the taking and not merely an indistinguishable share of the general benefit enjoyed by the public at large. The benefits to ERISA plan participants cited by the district court are no different than the benefits enjoyed by all other segments of society. It is difficult to imagine a state scheme that is a more perfect example of "forcing some people alone to bear public burdens which, in all fairness and justice, should be borne by the public as a whole" — the very type of governmental action that the Taking Clause of the Fifth Amendment was designed to bar. *Armstrong v. United States*, 364 U.S. 40, 49 (1960).

Although it seems anomalous to discuss ERISA plans in terms of "investment-backed expectations," there is a consideration analogous to this factor. The employers' contributions to these plans and their employees' acceptance of those contributions in lieu of other expenditures in the wage/benefit package can certainly be likened to the investment of resources. The circuit court's evocation of "the historically heavy and constant regulation of health care in New Jersey" (23a) to sweep aside the interference with investment-backed expectations is obtuse indeed. ERISA itself establishes the regulatory expectation of plans and participants covered by the federal legislation, and that expectation is complete freedom from state interference. ERISA plans and their participants have more than a mere investment-backed expectation; they have a congressionally-created expectation that their plan assets would be protected from state predators.

Since the cost-shifting provisions of the New Jersey statute could not be anticipated by ERISA-protected plans and participants, do not confer on them any benefit not enjoyed by the general public, and impose the burden of social welfare programs on only one small segment of the state population, these provisions amount to

an unconstitutional taking in violation of the Fifth Amendment to the Constitution of the United States, as interpreted by this Court.

With respect, then, to both pre-emption and to the Taking Clause the Third Circuit's decision fails to adhere to the holdings and principles set forth by this Court. Review is warranted to correct these untoward departures.

CONCLUSION

This ERISA pre-emption case arises in the field of healthcare, an area of burgeoning state activity and a subject of important national concern. The Third Circuit's decision is antagonistic to the repeated holdings of this Court, drastically cuts back on the scope of ERISA pre-emption, and opens the door to state manipulation of employee welfare plans so as to require them to use a significant portion of plan assets to finance social programs for the benefit of non-beneficiaries. Under the tests enunciated by this Court the state laws at issue here do not merely have a connection with or reference to ERISA welfare plans, they relate to them in a way that amounts to an unconstitutional taking of property. A prompt resolution of these substantial issues by the Supreme Court is necessary to prevent untold harm to ERISA plans, hospitals, and state treasuries nationwide and to deter a cut-back in collectively bargained welfare benefits in derogation of the congressional purposes embodied in ERISA. For these reasons the petition for a writ of certiorari should be granted.

Dated: New York, New York
July 22, 1993

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(2)

No. 93-115

Supreme Court, U.S.
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

NYSA-ILA WELFARE FUND, by its Trustees, JOHN BOWERS, ALBERT CERNADAS, FRANK LONARDO, THOMAS POPOLA, JAMES CAPO, JOSEPH N. BARBERA, BART DiMATTINA, and RICHARD H. O'NEILL,

Petitioner,

v.

FRANCIS J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; AND COLUMBUS HOSPITAL, EAST ORANGE GENERAL HOSPITAL, ST. JAMES HOSPITAL, and UNIVERSITY HOSPITAL, individually and as Class Representatives of Hospitals in the State of New Jersey; and NEW JERSEY HOSPITAL ASSOCIATION, as Class Representative of Hospitals in the State of New Jersey,

Respondents.

APPENDIX TO PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

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Filed May 14, 1993

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

Nos. 92-5317/5319/5320/
5341/5343/5345/5352/5354/5355

UNITED WIRE, METAL AND MACHINE HEALTH AND WELFARE FUND; JACK STOLL; ESTHER BORJA; JAVIER RESTREPO; UNITED FOOD AND COMMERCIAL WORKERS INTERNATIONAL UNION LOCAL 464A, AFL-CIO GROUP REIMBURSEMENT WELFARE PLAN; FRANK LACATENA; DOLORES LACATENA; NEW JERSEY CARPENTERS WELFARE FUND; LOCAL #807 LABOR-MANAGEMENT HEALTH FUND; TRUSTEES OF THE LOCAL #807 LABOR-MANAGEMENT HEALTH FUND; PROSPER ALEXANDER; MARIE ALEXANDER; DISTRICT COUNCIL OF IRONWORKERS OF NORTHERN NEW JERSEY WELFARE FUND; ARCHIE G. FERGUSON; RONALD W. JENSEN; JOHN J. IRVINE; WALTER PHILLIPS; MICHAEL J. MCDERMOTT; SAMUEL PACICH; ALBERT J. IRWIN; NICHOLAS J. ANDRETTA, SR.; GARY UGARO; WALTER F. STEINMETZ; JOHN D. MULVANY; MICHAEL W. FEATHERSON; FRANCIS E. ARNY; JOHN J. CLARK, SR.; RONALD W. WILLIAMS; DANIEL J. PEREZ; KEITH E. ZDEP; EDWARD WEIDLER; LOUIS ROCCO; RAYMOND J. RODGERS; FRANCIS J. AKESSON; DONALD J. BANTA, SR.; CHARLES W. BIRD; DAVID F. BROWN; CLIFFORD CROOKS; ROBERT T. CUSICK; JAMES P. FITZGERALD; JOSEPH A. FUSARO; CHARLES GAMBA; RICHARD GOUGEON; JOHN KEATING; GERARD MCCLOUD; ROBERT MCGEE; ALEXANDER MCLELLAN; JOHN MURPHY; LAURENCE O'BRIEN; PETER O'CONNER; RAUL RODRIGUEZ; ROBERT SCHWEITZER; ROBERT SICKLES; ANDREW L. SMITH; RICHARD SPARKS; GEORGE SUDAK; EDWARD TEDESCO; JAMES TOAL; ENOCH P. MCMAHON; LOCAL UNION 400; IBEW WELFARE FUND;

BRIAN HRUSKA; WILLIAM MARSH; CHARLES WORK; HAROLD RUTLEDGE; RALPH ALLEN; THOMAS VADAS; VINCENT WORTH; TIMOTHY HILL; RONALD RAMSEY; JOHN IRELAND; JAMES MARTIN; MICHAEL ALMASI; BEVERLY A. RUBY; PETER NAMOTKA; DANIEL KENNEDY; GEORGE COLE; WALTER DAVIES; ROBERT HERMANN; FRANK HERMANN; CHARLES KELLER; DENNIS JOHNSON; CONNIE J. KOEHLER; FRANK O'DAY; VINCENT LA STELLA; DONALD MCNEIL; JEAN-LOUIS POULIOT; NICHOLAS AEMISEGO; ROBERT STAHNKE; PHILIP CERZA; GARY GIORGIO; EDWARD OSOWSKI; GLENN HALVORSEN; WILLIAM STADELMAN; DANIEL JULIO, JR.; FRANCIS ALEXANDER; LEONARD DAHL; MICHAEL DEVINE; JOSEPH GEORGE; RALPH JENSEN; DONALD LA BRUTTO; NORMAN GRAMLICH; JUAN ROMERO; JOSEPH PIWOSKI; HARRY PEASE, JR.; EUGENE O'ROURKE; PAUL NIEDZINSKI; BERNARD WALL; STEPHEN KOJAC; CHARLES KRUPKA; WILLIAM MCCORMACK; MINOR KENNARD; STEPHEN J. SANGLE; DONALD SCHIRALDO; JOHN GACINA, III; BRIAN MCCARTHY; CHARLES MCNALLY; ROBERT CZAJOWSKI; BRIAN WOODALL; JEFFREY STAHNKE; JOHN RYAN; RALPH ROSAMILIA, SR.; DANIEL MUGAN; EDWARD MIRONSKI; MICHAEL MIDDINGS; ANDREW MAHASKY; WALTER JELINSKY; ALBERT GAECHTER; LOUIS DI MASCIO; ELLIOTT ROSEMAN; TRUSTEES OF THE OPERATING ENGINEERS LOCAL 825 WELFARE FUND; RICHARD HORNECKER; TEAMSTERS LOCAL 11 BENEFIT PLAN; TRUSTEES OF THE TEAMSTERS LOCAL 11 BENEFIT PLAN; KATLUSKA BAIDAL; WILLIAM BARTEL; GUNTER BLOHM; ANGELO BUINNO; BETTY J. CAIRNS; FRANK CLOSE; JOSE CRUZ; SANTOS GARCIA; KAREN GENSURE; DOROTHY LARSON; RICHARD LITCHFIELD; SANDRA MARINO; JOHN MATUSZKIEWICZ; GEORGE MCCLAUGHLIN; OLGA MONTES; FERNANDO PEREZ; SANTO RAMOS; MARTHA SARA; ROXEEN SCALA; EDMUND SCOTT; CHARLIE TAYLOR; MELISSA TURI, SANGPO TSULDIN; COSMO VISENTINI; NYSA-ILA WELFARE FUND; JOHN BOWERS; ALBERT CERNADAS; FRANK LONARDO; THOMAS POPOLA; JAMES CAPO; JOSEPH N. BARBERA; BART DIMATTINA; RICHARD H.

O'NEILL; LABORERS INTERNATIONAL UNION OF NORTH AMERICA LOCAL 415 HEALTH AND WELFARE FUND; SHEET METAL WORKERS LOCAL UNION NO. 25 WELFARE FUND; JEFFREY STAJEK; JAMES LUCIANO; JOHN A. FREUDENREICH, SR.; THOMAS SMIECH; JOSEPH MCCALLION; DANIEL SMITH, JR.; JAMES MCKAY; MARK COX; TRUSTEES OF THE TEAMSTERS LOCAL 641 WELFARE FUND; CARLOS ROCHA; GEORGE KOESTER; CARMELA FERENS; KHOONRAJIE RAGHUBANS; PHILLIP SAVITTIERI; EAR PATTERSON; ROBERT REEDER; LOCAL 1245, LOCAL 1245 HEALTH FUND; ANTHONY RIZZO; JOSEPH ABBATE; JOSEPH MASSOUD; RALPH MASTRANGELO; TRUSTEES OF THE WELFARE TRUST FUND, LOCAL UNION NO. 475; WILLIE A. BARNES; HERMAN GEIGER; VINSTON LEE KING; KEVIN E. KLINE; ROBERT L. ROSA; WILLIAM BRENNAN; JAMES MURPHY, JR.; PATRICIA MCELLIGOTT; KEVIN MCCORMICK; PATRICK RYAN, JR.; ANTHONY E. SMITH; ROBERT LAVERATT; JOHN S. WITTEK; JOHN MCQUILKEN; JOHN MONTESANO; ROY E. FRANK; JOHN O'NEILL, JR.; FRANK ROBINSON; DALE SCHAEFER; JOHN J. SERRA; DONALD SHERIDAN; WENCESLAO SOTO; MICHAEL J. RUSSO; JOSEPH P. MURPHY, JR.; CALVIN R. SUTTON, III; RONALD J. ZAKARZEWSKI; FRANK WHITNEY, SR.; JACK NACHTIGALL; LAWRENCE PARKIN; EDISON RODRIQUEZ; WILLIAM MORAN; VINCENT DOFFONT; GEORGE STOUT; BRIAN LUBECK; AMERICO GUGLIELMO; DAVID VADAS; CHRISTOPHER ANDREWSKI; DAVID JENKINS; ARTHUR ACKERMAN; KENNETH FINTON; RAMON LORENZO; WESLEY SANDERSON; CHARLES NEWMAN, III; LEONARD IAROSSI; GEORGE ROSSI; WILLIAM SKIECZIUS; JOHN HANCOCK; EDWARD THORNE; JOSEPH TAGLIADIA; MICHAEL MACHANSKA; STEVE PARLACASK

v.

MORRISTOWN MEMORIAL HOSPITAL; FRANCES J. DUNSTON; NEW JERSEY COMMISSIONER OF HEALTH; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; NEW JERSEY COMMISSIONER OF HEALTH; FRANCES DUNSTON; MEMORIAL HOSPITAL OF BURLINGTON COUNTY; THE MEDICAL CENTER OF OCEAN COUNTY;

KIMBALL MEDICAL CENTER; MERCER MEDICAL CENTER; OUR LADY OF LOURDES HOSPITAL; PRINCETON MEDICAL CENTER; HOSPITAL OF SALEM COUNTY; NEWCOMB MEDICAL CENTER; RIVERVIEW MEDICAL CENTER; COMMUNITY MEDICAL CENTER; SHORE MEMORIAL HOSPITAL; BURDETTE TOMLIN MEMORIAL HOSPITAL; CHRIST HOSPITAL; NEWARK BETH ISRAEL MEDICAL CENTER; ST. JOSEPH'S HOSPITAL; WAYNE GENERAL HOSPITAL; SOUTH JERSEY HOSPITAL SYSTEM; COOPER HOSPITAL; WEST JERSEY HEALTH SYSTEMS; ATLANTIC CITY MEDICAL CENTER; UNION MEMORIAL HOSPITAL; ELIZABETH GENERAL HOSPITAL; ENGLEWOOD HOSPITAL; ROBERT WOOD JOHNSON UNIVERSITY HOSPITAL; BARNERT MEMORIAL HOSPITAL; PASSAIC GENERAL HOSPITAL; RAHWAY HOSPITAL; VALLEY HOSPITAL; HOLY NAME HOSPITAL; ST. PETER'S MEDICAL CENTER; SOMERSET MEDICAL CENTER; OVERLOOK HOSPITAL; ST. ELIZABETH HOSPITAL; DOVER GENERAL MEDICAL CENTER; HUNTERDON MEDICAL CENTER; CHILTON MEMORIAL HOSPITAL; KESSLER MEMORIAL HOSPITAL; FREEHOLD AREA HOSP.; KENNEDY MEMORIAL HOSPITAL; UNIVERSITY HOSPITAL; UNDERWOOD MEMORIAL HOSPITAL; JERSEY CITY MEDICAL CENTER; ST. JOSEPH'S HOSPITAL; ST. BARNABAS MEDICAL CENTER; RARITAN BAY MEDICAL CENTER; CLARA MAASS MEDICAL CENTER; ST. CLARES/RIVERSIDE MEDICAL CENTER; JOHN F. KENNEDY MEDICAL CENTER; HACKETTSTOWN COMMUNITY HOSPITAL; ZURBRUGG MEMORIAL HOSPITAL; JERSEY SHORE MEDICAL CENTER; MONMOUTH MEDICAL CTR; NEWTON MEMORIAL HOSPITAL; UNIVERSITY OF MEDICINE & DENTISTRY OF NEW JERSEY; DEBORAH HEART AND LUNG CENTER; HOSPITAL CENTER AT ORANGE; DOVER GENERAL HOSPITAL; WEST JERSEY HEALTH SYSTEM; RARITAN BAY MEDICAL CENTER; HACKENSACK MEDICAL CENTER; SOUTH AMBOY MEMORIAL HOSPITAL; THE MOUNTAINSIDE HOSPITAL; ST. FRANCIS HOSPITAL; BAYONNE HOSPITAL; MUHLENBERG HOSPITAL; CENTRASTATE (FAH) HOSPITAL, ST. JAMES HOSPITAL; KENNEDY MEMORIAL HOSPITAL AT SADDLE

BROOK; ADMINISTRATOR OF THE NEW JERSEY HEALTH CARE TRUST FUND; NEW JERSEY DEPARTMENT OF HUMAN SERVICES (DIVISION) OF MEDICAL ASSISTANCE AND HEALTH SERVICES; ELIZABETH GENERAL MEDICAL CENTER; DOVER GENERAL MEDICAL CENTER; IRVINGTON GENERAL HOSPITAL; UNION HOSPITAL; WARREN HOSPITAL, COLUMBUS HOSPITAL; EAST ORANGE GENERAL HOSPITAL, FRANCIS DUBEAU; LILLIAN DUBEAU; BAYSHORE COMMUNITY HOSPITAL; NEW JERSEY HOSPITAL ASSOCIATION; BERGEN PINES COUNTY HOSPITAL; COMMUNITY MEMORIAL HOSPITAL; GREENVILLE HOSPITAL; MONTCLAIR COMMUNITY (HOSPITAL) PALISADES GENERAL HOSPITAL; PASSAIC BETH ISRAEL HOSPITAL; RARITAN BAY MEDICAL CENTER/PERTH AMBOY DIVISION; RIVERVIEW MEDICAL CENTER; SOUTHERN OCEAN COUNTY HOSPITAL; ST. MARY'S HOSPITAL; THE GENERAL HOSPITAL CENTER AT PASSAIC; WALLKILL VALLEY HOSPITAL AND HEALTH CENTERS; ST. MARY'S HOSPITAL (PASSAIC); UNITED HOSPITAL; PASCACK VALLEY HOSPITAL; WEST HUDSON HOSPITAL; JOHNSON UNIVERSITY HOSPITAL; ADMINISTRATOR OF THE NEW JERSEY HEALTH CARE TRUST FUND; NEW JERSEY DEPARTMENT OF HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES; NEW JERSEY HOSPITAL; NEW JERSEY HOSPITAL ASSOCIATION,

Intervenor-Defendants

(Newark New Jersey District Consolidated Lead Civil No. 90-02639)

UNITED WIRE, METAL AND MACHINE HEALTH AND WELFARE FUND; ESTHER BORJA

v.

ST. MARY'S HOSPITAL HOSPITAL; NEW JERSEY COMMISSIONER OF HEALTH; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; FRANCES J. DUNSTON;

(Newark New Jersey District Civil No. 90-03640)

UNITED WIRE, METAL AND MACHINE HEALTH AND WELFARE FUND; JAVIER RESTREPO

v.

ST. JOSEPH'S HOSPITAL AND MEDICAL CENTER; FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION

(Newark New Jersey District Civil No. 91-00073)

UNITED FOOD AND COMMERCIAL WORKERS INTERNATIONAL UNION, LOCAL 464A, AFL-CIO GROUP REIMBURSEMENT WELFARE PLAN; FRANK LACATENA; DOLORES LACATENA

v.

WAYNE GENERAL HOSPITAL; FRANCES J. DUNSTON; NEW JERSEY COMMISSIONER OF HEALTH; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION

(Newark New Jersey District Civil No. 91-00336)

DISTRICT COUNCIL OF IRONWORKERS OF NORTHERN NEW JERSEY WELFARE FUND; ARCHIE G. FERGUSON; RONALD W. JENSEN; JOHN J. IRVINE, WALTER PHILLIPS; MICHAEL J. MCDERMOTT; SAMUEL PACICH; ALBERT J. IRWIN, NICHOLAS J. ANDRETTA, SR.; GARY UGARO; WALTER F. STEINMETZ; JOHN D. MULVANEY; MICHAEL W. FEATHERSON; FRANCIS E. ARNY; JOHN J. CLARK, SR.; RONALD W. WILLIAMS; DANIEL J. PEREZ; KEITH E. ZDEP; EDWARD WEIDLER; LOUIS ROCCO; RAYMOND J. RODGERS; FRANCIS J. AKESSON; DONALD J. BANTA, SR; CHARLES W. BIRD; DAVID BROWN; CLIFFORD CROOKS; ROBERT T. CUSICK; JAMES P. FITZGERALD; JOSEPH A. FUSARO; CHARLES GAMBA; RICHARD GOUGEON; JOHN KEATING; GERARD MCCLOUD; ROBERT MCGEE; ALEXANDER MCLELLAN; JOHN MURPHY; LAURENCE O'BRIEN; PETER O'CONNER; RAUL RODRIGUEZ; ROBERT SCHWEITZER; ROBERT SICKLES; ANDREW L. SMITH;

RICHARD SPARKS; GEORGE SUDAK; EDWARD TEDESCO; JAMES TOAL; ENOCH P. MCMAHAN

v.

FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; DEBORAH HEART AND LUNG CENTER; HUNTERDON MEDICAL CENTER; ST. FRANCIS HOSPITAL; HOSPITAL CENTER AT ORANGE; ST. PETERS MEDICAL CENTER; ST. CLARES/RIVERSIDE MEDICAL CENTER; JOHN F. KENNEDY MEDICAL CENTER; DOVER GENERAL HOSPITAL; ST. BARNABAS MEDICAL CENTER; VALLEY HOSPITAL; OVERLOOK HOSPITAL; RAHWAY HOSPITAL; NEWTON MEMORIAL HOSPITAL; WEST JERSEY HEALTH SYSTEM; RARITAN BAY MEDICAL CENTER; HACKENSACK MEDICAL CENTER; CLARA MAASS MEDICAL CENTER; HOLY NAME HOSPITAL; NEWARK BETH ISRAEL MEDICAL CENTER; BAYONNE HOSPITAL; CHILTON MEMORIAL HOSPITAL; ST. JOSEPH'S HOSPITAL; MUHLENBERG HOSPITAL; COMMUNITY MED CENTER; CHRIST HOSPITAL; SOUTH AMBOY MEMORIAL HOSPITAL; CENTRASTATE (FAH) HOSPITAL; WAYNE GENERAL HOSPITAL; PRINCETON MEDICAL CENTER; ST. JAMES HOSPITAL,a/k/a CATHEDRAL HEALTH SERVICES, INC.; MOUNTAINSIDE HOSPITAL; PASSAIC GENERAL HOSPITAL; NEW JERSEY HOSPITAL ASSOCIATION

Intervenor/Defendant

(Newark New Jersey District Civil No. 91-02190)

NEW JERSEY CARPENTERS WELFARE FUND

v.

FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; SOUTH JERSEY HOSPITAL SYSTEM; COOPER HOSPITAL; WEST JERSEY HEALTH SYSTEMS; ATLANTIC CITY MEDICAL CENTER; MEMORIAL HOSPITAL OF BURLINGTON COUNTY; THE MEDICAL CENTER OF OCEAN COUNTY; KIMBALL MEDICAL CENTER; MERCER MEDICAL CENTER; OUR LADY OF

LOURDES; PRINCETON MEDICAL CENTER; HOSPITAL OF SALEM COUNTY; NEWCOMB MEDICAL CENTER; RIVERVIEW MEDICAL CENTER; COMMUNITY MEDICAL CENTER; SHORE MEMORIAL HOSPITAL; BURDETTE TOMLIN MEMORIAL; CHRIST HOSPITAL; MORRISTOWN MEMORIAL HOSPITAL; NEWARK BETH ISRAEL MEDICAL CENTER; WAYNE GENERAL HOSPITAL; UNION MEMORIAL HOSPITAL; ELIZABETH GENERAL HOSPITAL; ENGLEWOOD HOSPITAL, ROBERT WOOD JOHNSON UNIVERSITY HOSPITAL; BARNERT MEMORIAL HOSPITAL; PASSAIC GENERAL HOSPITAL; RAHWAY HOSPITAL; THE VALLEY HOSPITAL; HOLY NAME HOSPITAL; ST. PETER'S MEDICAL CENTER; SOMERSET MEDICAL CENTER; OVERLOOK HOSPITAL; ST. ELIZABETH HOSPITAL; DOVER GENERAL MEDICAL CENTER; HUNTERDON MEDICAL CENTER; CHILTON MEMORIAL HOSPITAL; KESSLER MEMORIAL HOSPITAL; FREEHOLD AREA HOSPITAL; KENNEDY MEMORIAL HOSPITAL; UNIVERSITY HOSPITAL; UNDERWOOD MEMORIAL HOSPITAL; JERSEY CITY MEDICAL CENTER; ST. JOSEPH'S HOSPITAL; ST. BARNABAS MEDICAL CENTER; RARITAN BAY MEDICAL CENTER; CLARA MAASS MEDICAL CENTER; ST. CLARE'S/RIVERSIDE MEDICAL CENTER; JOHN F. KENNEDY MEDICAL CENTER; HACKETTSTOWN COMMUNITY HOSPITAL; ZURBRUGG MEMORIAL HOSPITAL; JERSEY SHORE MEDICAL CENTER; MONMOUTH MEDICAL CENTER; NEWTON MEMORIAL HOSPITAL; NEW JERSEY HOSPITAL, NEW JERSEY HOSPITAL ASSOCIATION

Intervenor/Defendant

(Newark New Jersey District Civil No. 91-03280)

LOCAL #807 LABOR-MANAGEMENT HEALTH FUND; TRUSTEES OF THE LOCAL #807 LABOR-MANAGEMENT HEALTH FUND; PROSPER ALEXANDER; MARIE ALEXANDER

v.

UNIVERSITY HOSPITAL; UNIVERSITY OF MEDICINE & DENTISTRY OF NEW JERSEY; FRANCES J. DUNSTON, in

her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION

(Newark New Jersey District Civil No. 91-03286)

LOCAL UNION 400, IBEW WELFARE FUND; BRIAN HRUSKA; WILLIAM MARSH; CHARLES WORK; HAROLD RUTLEDGE; RALPH ALLEN; THOMAS VADAS; VINCENT WORTH; TIMOTHY HILL, RONALD RAMSEY; JOHN IRELAND; JAMES MARTIN

v.

FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; THE MEDICAL CENTER OF OCEAN COUNTY; RIVERVIEW MEDICAL CENTER; COMMUNITY MEDICAL CENTER; JERSEY SHORE MEDICAL CENTER; KIMBALL MEDICAL CENTER; MONMOUTH MEDICAL CENTER NEW JERSEY HOSPITAL ASSOCIATION

Intervenor/Defendant

(Newark New Jersey District Civil No. 91-03897)

OVERLOOK HOSPITAL

v.

FRANCES DUBEAU; LILLIAN DUBEAU

(Newark New Jersey District Civil No. 91-03910)

LABORERS INTERNATIONAL UNION OF NORTH AMERICA LOCAL 415 HEALTH AND WELFARE FUND

v.

FRANCES J. DUNSTON. in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION

(Newark New Jersey District Civil No. 91-04078)

NYSA-ILA WELFARE FUND, by its Trustees; JOHN BOWERS, Trustee; ALBERT CERNADAS, Trustee; FRANK LONARDO, Trustee; THOMAS POPOLA, Trustee; JAMES CAPO, Trustee;

JOSEPH N. BARBERA, Trustee; BART DIMATTINA, Trustee; RICHARD H. O'NEILL, Trustee

v.

FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; COLUMBUS HOSPITAL; EAST ORANGE GENERAL HOSPITAL ST. JAMES HOSPITAL; UNIVERSITY HOSPITAL, Individually and as Class Representatives of Hospitals in the State of New Jersey; NEW JERSEY HOSPITAL ASSOCIATION,
as Class representative of Hospital in the State of New Jersey

(Newark New Jersey District Civil No. 91-04259)

SHEET METAL WORKERS LOCAL UNION NO. 25 WELFARE FUND; JEFFREY STAJEK; JAMES LUCIANO; JOHN A. FREUDENREICH, SR.; THOMAS SMIECH; JOSEPH MCCALLION; DANIEL SMITH, JR.; JAMES MCKAY; MARK COX

v.

FRANCES J. DUNSTON, in her capacity of New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; ADMINISTRATOR OF THE NEW JERSEY HEALTH CARE TRUST FUND; NEW JERSEY DEPARTMENT OF HUMAN SERVICES (DIVISION) OF MEDICAL ASSISTANCE AND HEALTH SERVICES; NEW JERSEY HOSPITAL ASSOCIATION; ST. BARNABAS MEDICAL CENTER; HOLY NAME HOSPITAL; HACKENSACK MEDICAL CENTER; WEST HUDSON HOSPITAL; OVERLOOK HOSPITAL; JOHN F. KENNEDY MEDICAL CENTER; HUNTERDON MEDICAL CENTER; MORRISTOWN MEMORIAL HOSPITAL; IRVINGTON GENERAL HOSPITAL; CLARA MAASS MEDICAL CENTER

(Newark New Jersey District Civil No. 91-04700)

TRUSTEES OF THE OPERATING ENGINEERS LOCAL 825 WELFARE FUND; RICHARD HORNECKER

v.

FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT

OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; ADMINISTRATOR OF THE NEW JERSEY HEALTH CARE TRUST FUND, NEW JERSEY DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

(Newark New Jersey District Civil No. 91-05362)

TEAMSTERS LOCAL 11 BENEFIT FUND; TRUSTEES OF THE TEAMSTERS LOCAL 11 BENEFIT PLAN; KATLUSKA BAIDAL; WILLIAM BARTELL; GUNTER BLOHM; ANGELO BUINNO; BETTY J. CAIRNS; FRANK CLOSE; JOSE CRUZ; SANTOS GARCIA; KAREN GENSURE; DOROTHY LARSON; RICHARD LITCHFIELD; SANDRA MARINO; JOHN MATUSZKIEWICZ; GEORGE MCCLAUGHLIN; OLGA MONTES; FERNANDO PEREZ; SANTO RAMOS; MARTHA SARA; ROXEEN SCALA; EDMUND SCOTT; CHARLIE TAYLOR; MELISSA TURI; SANGPO TSULDIN; COSMO VISENTINI

v.

BAYSHORE COMMUNITY HOSPITAL; CHILTON MEMORIAL HOSPITAL; CLARA MAASS MEDICAL CENTER; DOVER GENERAL HOSPITAL; ELIZABETH GENERAL MEDICAL CENTER; ENGLEWOOD HOSPITAL; HOLY NAME HOSPITAL; IRVINGTON GENERAL HOSPITAL; JERSEY CITY MEDICAL CENTER; PASSAIC GENERAL HOSPITAL; ST. FRANCIS HOSPITAL; ST. PETER'S MEDICAL CENTER; SOMERSET MEDICAL CENTER; UNION HOSPITAL; UNITED HOSPITAL; UNIVERSITY HOSPITAL; VALLEY HOSPITAL; WARREN HOSPITAL; FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION

(Newark New Jersey District Civil No. 92-00085)

TRUSTEES OF THE WELFARE TRUST FUND, LOCAL UNION NO. 475; WILLIE A. BARNES; HERMAN GEIGER; VINSTON LEE KING; KEVIN E. KLINE; ROBERT L. ROSA; WILLIAM BRENNAN; JAMES MURPHY, JR.; PATRICIA MCELLIGOTT; KEVIN MCCORMICK; PATRICK RYAN, JR.;

ANTHONY E. SMITH; ROBERT LAVERATT; JOHN S. WITTEK; JOHN MCQUILKEN; JOHN MONTESANO; ROY E. FRANK; JOHN O'NEILL, JR.; FRANK ROBINSON; DALE SCHAEFER; JOHN J. SERRA; DONALD SHERIDAN; WENCESLAO SOTO; MICHAEL J. RUSSO; JOSEPH P. MURPHY, JR.; CALVIN R. SUTTON, III; RONALD J. ZAKARZEWSKI; FRANK WHITNEY, SR.; JACK NACHTIGALL; LAWRENCE PARKIN; EDISON RODRIGUEZ; WILLIAM MORAN; VINCENT DOFFONT

v.

FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; ADMINISTRATOR OF THE NEW JERSEY HEALTH CARE TRUST FUND; NEW JERSEY DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES; WEST HUDSON HOSPITAL; UNIVERSITY OF MEDICINE & DENTISTRY; OVERLOOK HOSPITAL; MORRISTOWN MEMORIAL HOSPITAL; UNION HOSPITAL; RIVERVIEW MEDICAL CENTER; NORTHERN OCEAN HOSPITAL SYSTEM; COMMUNITY MEDICAL CENTER; HOSPITAL CENTER AT ORANGE; HUNTERDON MEDICAL CENTER; WARREN HOSPITAL; CENTRASTATE MEDICAL CENTER; SOMERSET MEDICAL CENTER; ROBERT WOOD JOHNSON UNIVERSITY; THE MEDICAL CENTER OF OCEAN COUNTY; JERSEY SHORE MEDICAL CENTER; COLUMBUS HOSPITAL; JOHN F. KENNEDY MEDICAL CENTER; CLARA MAASS MEDICAL CENTER

(Newark New Jersey District Civil No. 92-00426)

TEAMSTERS LOCAL 641 WELFARE FUND; CARLOS ROCHA; GEORGE KOESTER; CARMELA FERENS; KHOONRAJIE RAGHUBANS; PHILLIP SAVITTIERI; EARL PATTERSON; ROBERT REEDER

v.

FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; MEDICAL CENTER OF OCEAN COUNTY; ST. BARNABAS MEDICAL CENTER; CLARA MAASS

MEDICAL CENTER; ST. ELIZABETH HOSPITAL; PASSAIC GENERAL HOSPITAL

(Newark New Jersey District Civil No. 92-00526)

LOCAL 1245 HEALTH FUND; LOCAL 1245 BAKERY AND SPECIALTY HEALTH FUND; JAMES ARBOLINO; ANTHONY ROCCO; HAROLD POLSKY; NEVIO MANCIINI; WILLIE SCONIERS; IRENE HICKEY; KATHLEEN RODRIGUEZ; WILLIAM CLACKWORTHY; EDWARD NELSON; PATRICIA CONRAD; RONALD COZZO; HOLLY ANN CULBERT; JOACHIM SCHAFFRANIETZ; HUBERT CHASE; ROBERT BAUMAN; RUSSELL SCHWARTZ; JEAN JACQUES KERVAN; ARTHUR BEYER

v.

FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; DOVER GENERAL HOSPITAL; THE MEDICAL CENTER OF OCEAN COUNTY; SAINT BARNABAS MEDICAL CENTER; UNION HOSPITAL; JOHN F. KENNEDY MEDICAL CENTER; ENGLEWOOD HOSPITAL; MORRISTOWN MEMORIAL HOSPITAL; CENTRASTATE; SAINT PETER'S MEDICAL CENTER; SAINT MARY'S HOSPITAL; MEADOWLANDS HOSPITAL AND MEDICAL CENTER; JERSEY SHORE MEDICAL CENTER; KENNEDY MEMORIAL HOSPITAL; PASSAIC GENERAL HOSPITAL

(Newark New Jersey District Civil No. 92-00728)

ANTHONY RIZZO; JOSEPH ABBATE; JOSEPH MASSOUD; RALPH MASTRANGELO, as Trustees of the Local 945, I.B.T. Welfare Fund

v.

BARNERT MEMORIAL HOSPITAL CENTER; BAYONNE HOSPITAL; BAYSHORE COMMUNITY HOSPITAL; BERGEN PINES COUNTY HOSPITAL; CENTRASTATE MEDICAL CENTER; CHILTON MEMORIAL HOSPITAL; CHRIST HOSPITAL; CLARA MAASS MEDICAL CENTER; COLUMBUS HOSPITAL; COMMUNITY MEMORIAL HOSPITAL; DOVER GENERAL HOSPITAL & MEDICAL

CENTER; ELIZABETH GENERAL MEDICAL CENTER; GREENVILLE HOSPITAL; HACKETTSTOWN COMMUNITY HOSPITAL, HOLY NAME HOSPITAL; IRVINGTON GENERAL HOSPITAL; JERSEY SHORE MEDICAL CENTER; JOHN F. KENNEDY MEDICAL CENTER; KENNEDY MEMORIAL HOSPITALS AT SADDLE BROOK; KIMBALL MEDICAL CENTER; MERCER MEDICAL CENTER; MONTCLAIR COMMUNITY (HOSPITAL); MORRISTOWN MEMORIAL HOSPITAL; NEWTON MEMORIAL HOSPITAL; OVERLOOK HOSPITAL; PALISADES GENERAL HOSPITAL, PASCACK VALLEY HOSPITAL; PASSAIC BETH ISRAEL HOSPITAL; RAHWAY HOSPITAL; RARITAN BAY MEDICAL CENTER/PERTH AMBOY DIVISION; RIVERVIEW MEDICAL CENTER; ROBERT WOOD JOHNSON UNIVERSITY HOSPITAL; SOUTHERN OCEAN COUNTY HOSPITAL; ST. MARY'S HOSPITAL (PASSAIC); ST. JOSEPH'S HOSPITAL & MEDICAL CENTER; ST. FRANCIS MEDICAL CENTER; ST. ELIZABETH HOSPITAL; ST. PETER'S MEDICAL CENTER; THE GENERAL HOSPITAL CENTER AT PASSAIC; UNION HOSPITAL; UNIVERSITY HOSPITAL; UNIVERSITY OF MEDICINE & DENTISTRY OF NEW JERSEY; VALLEY HOSPITAL; WALLKILL VALLEY HOSPITAL AND HEALTH CENTERS; WARREN HOSPITAL; WAYNE GENERAL HOSPITAL; FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION

(Newark New Jersey District Civil No. 92-00849)

NEWCOMB MEDICAL CENTER

v.

JENNIS CARPENTER; ALICE CARPENTER, his wife, jointly, severally and in the alternative

Defendants/Third Party Plaintiffs

v.

FRANCES J. DUNSTON; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; ADMINISTRATOR OF THE NEW JERSEY HEALTH CARE TRUST FUND; NEW JERSEY DEPARTMENT OF HUMAN SERVICES, DIVISION OF

MEDICAL ASSISTANCE AND HEALTH SERVICES
Third Party Defendants

(Newark New Jersey District Civil No. 92-01282)

NEWCOMB MEDICAL CENTER

v.

SHANA TRIPP; CHARLES TRIPP, jointly, severally and in the alternative

Defendants/Third Party Plaintiffs

v.

NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; ADMINISTRATOR OF THE NEW JERSEY HEALTH CARE TRUST FUND; NEW JERSEY DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES; FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health

Third Party Defendants

(Newark New Jerseys District Civil No. 92-01454)

NEWCOMB MEDICAL CENTER

v.

FRED KUEKEN
Defendant/Third Party Plaintiff

v.

FRANCES J. DUNSTON; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; ADMINISTRATOR OF THE NEW JERSEY HEALTH CARE TRUST FUND; NEW JERSEY DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
Third Party Defendants

(Newark New Jersey District Civil No. 92-01455)

New Jersey Hospital Association; Bayshore Community Hospital; Monmouth Medical Center; Pascack Valley Hospital; Riverview Medical Center; Kennedy Memorial Hospitals at Saddle Brook, Inc.; William B. Kessler Memorial Hospital; St. Francis Hospital;

South Jersey Hospital System; Helene Fuld Medical Center; Newton Memorial Hospital; The Medical Center of Ocean County; Bayonne Hospital; Kennedy Memorial Hospitals-University Medical Center; South Amboy Memorial Hospital; Underwood Memorial Hospital; Muhlenberg Regional Medical Center; Englewood Hospital; Zurbrugg Memorial Hospital; St. Mary Hospital; Community Medical Center; Hunterdon Medical Center; St. Michael's Medical Center; The Mercer Medical Center; St. Peter's Medical Center; Jersey Shore Medical Center; Irvington General Hospital; John F. Kennedy Hospital; Our Lady of Lourdes Medical Center; Overlook Hospital; Raritan Bay Medical Center; St. Elizabeth Hospital; Wayne General Hospital; Barnert Hospital; Atlantic City Medical Center; Dover General Hospital & Medical Center; Holy Name Hospital; The Hospital at Orange; St. Clare's/Riverside Medical Center; Clara Maas Medical Center; Deborah Heart & Lung Center; Rahway Hospital; West Jersey Health System; Hackensack Medical Center; Newark Beth-Israel Medical Center; St. James Hospital; St. Joseph's Hospital & Medical Center; Christ Hospital; Chilton Memorial Hospital; East Orange General Hospital; Columbus Hospital; Cooper Hospital/University Medical Center; Memorial Hospital of Burlington County Memorial Health Alliance; Medical Center at Princeton; St. Joseph's Hospital; Shore Memorial Hospital; Robert Wood Johnson University Hospital; Burdette Tomlin Memorial Hospital; Somerset Medical Center; Mountainside Hospital; Union Hospital; United Hospitals Medical Center at Passaic; and Morristown Memorial Hospital,

Appellants

On Appeal From the United States District Court For the District of New Jersey

(D.C. Civil Action Nos. 90-02639, 90-03640, 91-00073, 91-00336, 91-02190, 91-03280, 91-03286, 91-03897, 91-03910, 91-04078, 91-04259, 91-04700, 91-05362, 92-00085, 92-00426, 92-00526, 92-00728, 92-00849, 92-01282, 92-01454, 92-01455)

Argued September 18, 1992

BEFORE: STAPLETON, SCIRICA, and NYGAARD, *Circuit Judges*

(Opinion Filed May 14, 1993)

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OPINION OF THE COURT

STAPLETON, *Circuit Judge:*

Appellees, several self-insured employee benefit plans and a number of individual participants in those plans ("the plans"), brought this action seeking an injunction against the application to them of New Jersey's then current statutory scheme for setting hospital rates. They also sought restitution of monies paid under protest pursuant to that statutory scheme. Appellees argue both that the New Jersey statute was preempted by the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002 *et seq.*, as amended ("ERISA"), and that the statute worked an unconstitutional taking of property without just compensation. Appellants are numerous New Jersey hospitals, various agencies and officials of the state of New Jersey and, as an intervening party, the New Jersey Hospital Association ("the defendants").

The district court entered summary judgment in favor of the plans on their ERISA preemption claim and enjoined the enforcement of the statute as it applied to them. The injunction was stayed, pending this appeal. The district court also entered summary judgment in favor of the defendants on the plans' constitutional claims, and declined to reach the question of restitution. The defendants appeal, and the plans cross-appeal.

We will reverse the summary judgment on the ERISA preemption claim and vacate the injunction. We will affirm the summary judgment on the constitutional claims, and remand the case to the district court with instructions that judgment be entered for the defendants.

I.

The statutory and regulatory regime in question is found in the New Jersey Health Care Facilities Planning Act of 1971, as amended by the Health Care Cost Reduction Act of 1978, N.J. Stat. Ann. 26:2H-1 *et seq,* (both shall be collectively referred to as "Act") and the attending regulations. N.J. Admin. Code 8:31B *et seq.*

In 1978, New Jersey enacted a revised rate setting system. Chapter 83, the dual purpose of which was to "contain the rising costs of health care services, and to ensure the financial solvency of hospitals." N.J. Stat. Ann. 26:2H-1. Under this prospective rate-setting system, various medical procedures are divided into "diagnostic related groups" ("DRGs"), and a rate is assigned to each DRG. A particular hospital's DRG rate consists of a weighted average of the costs incurred by the hospital in treating a given condition and the average cost incurred by hospitals throughout the state to treat that condition. The system thus penalizes hospitals that incur costs greater than the state wide average and rewards hospitals that provide more efficient service for a particular DRG. Patients in the same DRG at a particular hospital pay the same bill regardless of the duration of their stays and the demands they make on the resources of the hospital.

The DRG rate is the base rate under New Jersey's system. A patient's bill will have other components, and it is these components that the plans challenge as inconsistent with ERISA. Hospitals in New Jersey are required by law to provide treatment for patients who cannot pay their bills. N.J. Admin. Code 8:436-5.2(c). Emergency services for the indigent are required by federal law as well. Thus, one cost of doing business for New Jersey hospitals is the cost of providing "uncompensated care." In order to pay for this care and to provide financial relief to those hospitals that provide more than their share of uncompensated care, a state wide charge is added to the DRG, and the resulting revenue is distributed in proportion to the uncompensated care provided by each hospital.

An additional surcharge is designed to compensate hospitals for the losses they incur when treating patients covered by Medicare. Hospitals that treat Medicare patients can charge those patients only the amount allotted by the federal Medicare agency for the particular treatment provided. Medicare now provides reimbursement at levels below the DRG rates. To enable New Jersey hospitals to make up for the resulting revenue shortfall, the current New Jersey

system allows hospitals to include in their billings to non-Medicare patients an amount necessary to recover the difference between the Medicare rate of payment and the DRG rate.

Chapter 83 also grants discounts to certain classes of payors. The relevant section provides in part:

> All payment rates shall be equitable for each payor or class of payors without discrimination or individual preference except for quantifiable economic benefits rendered to the institution or to the health care delivery system taken as a whole. In addition to other such benefits which the commission may consider, it shall consider the following, if found to be quantifiable: (1) degree of promptness and volume of payments to hospitals so that hospitals are provided with funds for current financing of their services, and (2) broad provision of health insurance coverages which are not self-supporting. In determining the quantifiable economic benefits to which consideration shall be given in approving payment rates, the commission may consider overall financial benefits to society which are provided by programs offered by a payor or class of payors.

26:2H-18b N.J. Stat. Ann. Pursuant to this provision, the commission granted a 2.2% discount to high-volume plans such as Blue Cross and granted an 11% discount to plans with open enrollment. Patients who do not belong to plans that received these discounts are billed at an increased rate to allow hospitals to recover the income lost by virtue of the discount. One of the plaintiff plans has applied for a discount under this portion of Chapter 83, but the commission has not yet ruled on its application.[1]

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[1] Individuals and third party payors can challenge a bill, through appeal, for such things as an alleged incorrect assignment of a DRG. Only an uninsured individual whose DRG bill exceeds his or her itemized medical costs by $250 may appeal "in exceptional cases of DRG assignments which, although technically correct, may produce grossly inequitable or excessive payments . . . . Upon demonstration, by substantial evidence, that application of the DRG system would result in inequitable consequences for the patient, the qualified utilization review organization may direct that payment be based on an alternative to the DRG rate (for example, charges)." N.J. Admin. Code 8:31B-3.78(a)viii. Unlike the surcharges to offset the costs of indigent care, Medicare, and payor discounts, the provision of Chapter 83 that allows some uninsured individuals to reduce their bills does not result in a specific surcharge that is added to the bills of other paying customers. This equitable over-ride for some uninsured individuals does not single out participants in ERISA plans for special treatment. It is not available to any individual who is entitled to reimbursement of medical expenses from any third party payor.

II.

At the threshold of our consideration we must determine whether this case is moot. The regulatory scheme we have just described was superseded by new state legislation on January 1, 1993. As we have noted, however, the plans seek not only an injunction against enforcement of the (now superseded) Act, but also restitution of monies paid by appellees pursuant to the Act while it was in effect. If the Act is infirm for either of the reasons asserted, the claim of restitution remains viable even though an injunction is no longer necessary. In order to adjudicate the merits of the restitution claim, we must determine if the monies were paid pursuant to an unlawful statutory scheme.[2] We thus turn our attention to an evaluation of the lawfulness of the Act.

III.

For the reasons set forth by the district court in its opinion, we find that the extra costs paid by the plans pursuant to the Act do not constitute an unlawful taking of property without just compensation. See, *United Wire, Health & Welfare Fund v. Morristown*, 794 F. Supp. 524, 540-42 (D.N.J. 1992).

In *Penn Central Transportation Co. v. New York City*, 438 U.S. 104 (1978), the Supreme Court utilized a three prong analysis to determine whether a governmental regulation constituted a taking. The *Penn Central* analysis directs our attention to (i) the character

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(Continued)

The record does not disclose how many uninsured individuals have filed appeals under the equitable over-ride provision, and we find no record basis for the suggestion that the "transparent goal ... of this appeal process" is to impose "the lion's share of [the cost of caring] for the uninsured" on New Jersey's ERISA plans. Dissenting Op., pp. 39, 41.

[2] The plans assert that 29 U.S.C. § 1132(a) and federal common law give them a right to recover the amounts they have paid to the hospitals under protest. The district court did not expressly determine whether § 1132(a) or the federal common law provided a right to restitution under the circumstances of this case. Its opinion, however, states that it "declines to exercise its pendent and supplemental jurisdiction over plaintiffs' restitution claims," 793 F.Supp. at 542, perhaps indicating that the district court may have viewed state law as providing the plaintiffs' only possible remedy. In view of our ultimate conclusion that chapter 83 is not preempted, we have no occasion to reach this issue. It is sufficient for our purposes to note that a case or controversy remains between the parties; the preemption issue is not moot because the plaintiffs make a claim for restitution, and an essential element of that claim is that ERISA's preemption provision has been violated.

of the governmental action; (ii) the economic impact of the regulation on the claimant; and (iii) the extent to which the regulation has interfered with investment backed expectations. *Penn Central* at 124. Regarding the character of the government action, we conclude that New Jersey "does not physically invade or permanently appropriate any of the [plan's] assets for its own use," but rather "adjusts the benefits and burdens of economic life to promote the common good". *Connolly v. Pension Guaranty Corp.*, 475 U.S. 211, 225 (1986). Similarly, the economic impact of the Act upon the appellees indicates that no taking has occurred. While appellees have been deprived of money by operation of the Act, the determination of the amount owed was not randomly generated, but was rather "directly related to the individual [appellee's] hospital bill." *United Wire*, 793 F.Supp. at 542. Finally, given the historically heavy and constant regulation of health care in New Jersey, we cannot say that the Act interfered with the plans' "investment backed expectations." We thus affirm the district court's summary judgment for the defendants on the constitutional claim.

IV.

Whether the Act is preempted by ERISA is a somewhat thornier question. Section 514(a) of ERISA provides that, with some exceptions that do not apply in this case, ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA. It is undisputed that the plans are covered by ERISA, and so the question to be determined is whether the Act "relate[s] to" the plans in a way that necessitates preemption. We find that the Act does not relate to the plans in a way that triggers ERISA's preemption clause.

The preemption clause of ERISA is notable for its breadth, and manifests Congress's intention to establish pension plan regulation as an exclusively federal concern. *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981). The Supreme Court has noted that a state law "relates to" an ERISA governed plan, within the meaning of § 514(a)'s preemptive reach, "if it has a connection with or reference to such a plan." *Shaw v. Delta Airlines*, 463 U.S. 85, 97 (1983). The Court in *Shaw* noted, however, that "[s]ome state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law "relates to" the plan. 463 U.S. at 100, n. 21.

In determining whether the New Jersey scheme of regulating hospital rates is preempted by ERISA, "as in any preemption analysis, 'the purpose of Congress is the ultimate touchstone.' " *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747 (1985) (quoting *Malone v. White Motor Corp.*, 435 U.S. 497, 504 (1978)). The Supreme Court discussed at length the Congressional intent behind the ERISA preemption clause in *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987). In *Fort Halifax* the Court was faced with the question of whether ERISA preempted a Maine statute requiring employers, in the event of a plant closing, to provide a one-time severance payment to employees not covered by an express contract providing for severance pay. In the course of holding that the Maine statute was not preempted, the Court explained the Congressional intent behind ERISA's preemption clause:

> [A]n employer that makes a commitment systematically to pay certain benefits undertakes a host of obligations, such as determining the eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payment, and keeping appropriate records in order to comply with applicable reporting requirements. The most efficient way to meet these responsibilities is to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits. Such a system is difficult to achieve, however, if a benefit plan is subject to differing regulatory requirements in differing States. A plan would be required to keep certain records in some States but not in others; to make certain benefits available in some States but not in others; to process claims in a certain way in some States but not in others; and to comply with certain fiduciary standards in some States but not in others.
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> It is thus clear that ERISA's pre-emption provision was prompted by recognition that employers establishing and maintaining employee benefit plans are faced with the task of coordinating complex administrative activities. A patch-work scheme of regulation would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them. Pre-emption

> ensures that the administrative practices of a benefit plan will be governed by only a single set of regulations.

Fort Halifax, 482 U.S. at 9, 11. It is with this Congressional purpose in mind that one must read the myriad of ERISA preemption cases that have been decided in the courts since ERISA was adopted. It informs the following analysis of these cases.

A rule of law relates to an ERISA plan if it is specifically designed to affect employee benefit plans,[3] if it singles out such plans for special treatment,[4] or if the rights or restrictions it creates are predicated on the existence of such a plan.[5] Because we are here dealing with a statute of general applicability that is designed to establish the prices to be paid for hospital services, which does not single out ERISA plans for special treatment, and which functions without regard to the existence of such plans, the cases which have cordoned off this area of preemption are inapplicable.[6]

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[3] *See, e.g., Bricklayers Local 33 v. America's Marble Source*, 950 F.2d 114 (3d Cir. 1991) (ERISA preempts a New Jersey statute that regulates the payment of fringe benefits); *McMahon v. McDowell*, 794 F.2d 100 (3d Cir. 1986) (ERISA preempts a Pennsylvania statute that allowed employees to collect unpaid ERISA plan benefits directly from the officers of a company, thus adding to the employee plans another means of collecting benefits), *cert. denied*, 479 U.S. 971 (1986).

[4] *See, e.g., Mackey v. Lanier Collection Agency and Service, Inc.*, 486 U.S. 825 (1988) (a portion of Georgia's garnishment statute "which singles out ERISA plan, by express reference, for special treatment is preempted." *Id.*, at 838, n. 12: *McCoy v. Massachusetts Institute of Technology*, 950 F.2d 13, 19 (1st Cir. 1991) (ERISA preempts a Massachusetts lien statute which "expressly singles out ERISA plans for special treatment."), *cert. denied*, 112 S.Ct. 1939 (1992).

[5] *E.g., District of Columbia v. Greater Washington Bd. of Trade*, 113 S.Ct. 580 (1992) (ERISA preempts a District of Columbia statute that required employers who provide health insurance for their employees to provide equivalent health insurance coverage for injured employees eligible for workers' compensation benefits); *Ingersoll-Rand Co. v. McClendon*, 111 S.Ct. 478 (1990) (ERISA preempts employee's state law wrongful discharge claim where claim was based on allegation that discharge was motivated by employer's desire to avoid making contributions to employee's pension fund).

[6] As the plans correctly point out, the Supreme Court has declared that the phrase "relates to" in § 514(a) is used "in the normal sense of the phrase" and has cited the definition of "Relate" found in Black's Law Dictionary. That definition includes "to refer to" as one accepted meaning. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97, n. 16 (1983). Nevertheless, we disagree with the plans' argument that Chapter 83 is preempted simply because it expressly refers to "self-funded union" plans as one example of a "third party payor". Where, as here, a reference to an ERISA plan can be excised without altering the legal effect of a statute in any way, we believe the reference should be regarded as without legal consequence for § 514(a) purposes. Thus, for example, a state statute providing that "no employer, including an ERISA plan, shall discriminate on grounds of race or gender" would not be preempted despite its reference to an ERISA plan. See footnote 11 *infra*.

This does not end our inquiry, however. A state rule of law may be preempted even though it has no such direct nexus with ERISA plans if its effect is to dictate or restrict the choices of ERISA plans with regard to their benefits, structure, reporting and administration, or if allowing states to have such rules would impair the ability of a plan to function simultaneously in a number of states.[7]

New Jersey's scheme may increase the charges billed to ERISA plan participants for hospital services. This will mean that for any plan which commits to pay all or some lesser percentage of a participant's hospital costs will be called upon to pay more in benefits than it otherwise would. This effect is no different in kind, however, from any state regulation that increases the cost of goods or services that hospitals consume and pass on in hospital costs, i.e., utility costs, the wages of its employees, waste disposal costs, etc. New Jersey's scheme does not direct ERISA plans to structure their

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We also disagree with the dissenting opinion's suggestion that a statute should be preempted solely because the participation of ERISA plans is required as a matter of economics in order for the statute to meet its social goals. This is not what we understand the Supreme Court to have meant in *Greater Washington Board of Trade* when it held that statutes predicated on the existence of ERISA plans "relate to" such plans. The statute in that case could not be applied without reference to the "coverage levels set forth in ERISA plans." As we understand it, it is of no legal consequence if removing ERISA plans from the scene would diminish the likelihood that the statute would meet its social goals. Rather, the test for preemption in this regard is whether the existence of ERISA plans is necessary for the statute to be meaningfully applied. *Greater Washington Board of Trade,* 113 S.Ct. at 583-84.

[7] *See, e.g., FMC Corp. v. Holiday*, 111 S.Ct. 403, 408 (1990) (ERISA preempts a Pennsylvania antisubrogation statute which prevented Pennsylvania plans "from being structured in a manner requiring reimbursement in the event of recovery from a third party"); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981) (ERISA preempts New Jersey statute insofar as that statute prevents ERISA plans from decreasing benefits by the amount a recipient is awarded in worker's compensation subsequent to retirement); *Hampton Industries Inc. v. Sparrow*, 981 F.2d 726 (4th Cir. 1992); (ERISA preempts a North Carolina antisubrogation statute); *National Elevator Industry, Inc. v. Calhoun*, 957 F.2d 1555, 1561 (10th Cir. 1992) (ERISA preempts administrative interpretation of Oklahoma's prevailing wage statute insofar as it determines rates of pay and "may be used to effect change in the administration, structure and benefits of an ERISA plan"), *cert. denied*, 113 S.Ct. 406; *Michigan Carpenters Council v. C. J. Rogers, Inc.*, 933 F.2d 376 (6th Cir. 1991) (ERISA preempts Michigan state corporate reorganization statute that allows employers unilaterally to alter their obligation to ERISA plans), *cert. denied*, 112 S.Ct. 585 (1991); *Arkansas Blue Cross & Blue Shield v. St. Mary's Hospital*, 947 F.2d 1341 (8th Cir. 1991) (ERISA preempts Arkansas statute regulating the assignment of benefits to health care providers), *cert. denied*, 112 S.Ct. 2305 (1992).

benefits or conduct their internal affairs in any particular way. Nor does it deprive ERISA plans of any alternative they would otherwise have in these areas. Finally, since the cost of hospital services will necessarily vary from region to region, we fail to see how state regulation of hospital pricing like that chosen by New Jersey is likely to make interstate operation of an ERISA plan more difficult.

Where there is no direct nexus between a state statute and ERISA plans, no effect on the manner of such plans' conducting business or their ability to operate in interstate commerce, statutes have been upheld despite the fact that they may have the indirect ultimate effect of increasing plan costs. In *Mackey v. Lanier Collection Agency and Service, Inc.*, 486 U.S. 825 (1988), for example, the court held that Georgia's general statute authorizing garnishment of obligations due debtors could be utilized by creditors of ERISA plan participants to require the application of plan benefits to satisfy participants' personal debts. Georgia garnishment law as so applied was found not to be preempted by § 514(a) despite the fact that "benefit plans subjected to garnishment . . . incur substantial administrative burdens and costs" in responding to garnishment summons.

The most helpful case in the present context is *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), where the court sustained against a preemption challenge a New York statute setting the rates that hospitals in that state had to charge patients, including those who were participants in self-insured employee benefit plans. The court, after noting the obvious "fact that ERISA plan members and managers are bound to engage in myriad transactions that Congress never considered when it drafted § 514," made the following observations that seem equally pertinent here:

> A preemption provision designed to prevent state interference with federal control of ERISA plans does not require the creation of a fully insulated legal world that excludes these plans from regulation of any purely local transaction.
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> The purchase of hospital service is like the purchase of public utility service, or of any other service or commodity whose price is controlled by the State. Insofar as the regulation of hospital rates affects a plan's cost of doing business, it also may be analogized to State labor laws that govern working conditions and labor costs, to rent control laws that determine

> what employee benefit plans pay or receive for rental property, and even to such minor costs as the Thruway, bridge and tunnel tolls that are charged to plans' officers or employees. In short, if ERISA is held to invalidate every State action that may increase the cost of operating employee benefit plans, those plans will be permitted a charmed existence that never was contemplated by Congress. Where, as here, a State statute of general application does not affect the structure, the administration, or the type of benefits provided by an ERISA plan, the mere fact that the statute has some economic impact on the plan does not require that the statute be invalidated.
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> Moreover, such indirect economic impact as may result from State control over hospital rates does not run counter to ERISA's aim of national uniformity in plan regulation. *See Shaw v. Delta Air Lines, Inc.*, *supra*, 103 S.Ct. at 2890 n. 20. There is no valid reason why employee benefit plans cannot be subject to nationally uniform supervision despite dissimilarities in their costs of doing business. Indeed, if statutes such as section 2807-a(6)(b) of New York's Public Health Law are held to be preempted by ERISA, every hospital will be able to set its own rates for ERISA plans, and appellee does not contend that these rates are, or will be, uniform, even as between hospitals in the same locality.

749 F.2d at 138-9.

The plans insist that *Rebaldo* is no longer "good law" in light of the Supreme Court's subsequent decision in *Ingersoll-Rand Co. v. McClendon*, 111 S.Ct. 478 (1990). While we agree that a portion of the *Rebaldo* court's analysis was rejected in *Ingersoll-Rand*, the above-quoted reasoning remains persuasive and we are confident that *Rebaldo* would have been decided in the same way if the court had had the benefit of the teachings of *Ingersoll-Rand*.[8]

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[8] We thus find ourselves unpersuaded by the Southern District of New York's recent opinion in *Travelers Insurance Co. v. Cuomo*, 813 F. Supp. 996, which suggested that *Rebaldo* has been entirely eroded by opinions of the Supreme Court. The opinion proceeds from what appears to us to be a misconstruction of the Supreme Court's opinion in *FMC Corp. v. Holliday*, 111 S. Ct. 403 (1990). The court in that case seems to understand FMC to have been concerned with presenting uniform costs of doing business to plan administrators. By our reading, however, FMC was concerned to prevent a state statute from forcing decisions regarding the internal design and structure of benefit plans (e.g. who may collect, and how, and from whom).

In *Ingersoll-Rand*, the Supreme Court addressed the issue of whether § 514(a) preempts a state cause of action in favor of an employee terminated to prevent the vesting of his or her pension benefits. It was confronted with an argument that the phrase "relate to any employment benefit plan" should be read in the context of § 514 as a whole and that the wording of §514(c)(2) indicates that § 514 preempts only a state law which "purports to regulate, . . . directly or indirectly, the terms and conditions of employee benefits plans." 29 U.S.C. §1144(c)(2).[9] If § 514(c)(2) did so limit the scope of § 514, the state cause of action at issue would not be preempted because it did not purport to regulate the terms and conditions of ERISA plans. The Supreme Court determined, however, that §514 preemption was not so limited and that it extended to a state cause of action predicated on the existence of an employee benefit plan. Since one of the elements of the state cause of action was the existence of such a plan, the Supreme Court had "no difficulty in concluding" that it was preempted. *Id.* at 483. It explained,

> . . . We are not dealing here with a generally applicable statute that makes no reference to, or indeed functions irrespective of, the existence of an ERISA plan. Nor is the cost of defending this lawsuit a mere administrative burden. Here, the existence of a pension plan is a critical factor in establishing liability under the State's wrongful discharge law. As a result, this cause of action relates not merely to pension benefits, but to the essence of the pension *plan* itself.

While the court in *Rebaldo* did suggest that § 514(c)(2) could be read to limit the scope of § 514 preemption,[10] this was not the touchstone of its analysis. Unlike the court in *Ingersoll-Rand*, the *Rebaldo* court *was* "dealing ... with a generally applicable statute that makes no reference to, [and] functions irrespective of, the existence of an ERISA plan." *Id.* at 483, and that affects such plans only by increasing their costs of doing business. As the above-quoted portions of the opinion bear witness, it was the absence of a direct nexus to ERISA plans and the limited nature of the statute's impact on such plans that put the pricing regulation in *Rebaldo* beyond the scope of § 514 preemption.[11]

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[9] Section 514(c)(2) reads in full:

> The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly

In summary, we, too, have before us a generally applicable law which (1) is not intended to regulate the affairs of ERISA plans, (2) neither singles out such plans for special treatment nor predicates rights or obligations on the existence of an ERISA plan, and (3) does not have either the effect of dictating or restricting the manner in which ERISA plans structure or conduct their affairs or the effect of impairing their ability to operate simultaneously in more than one state. We have found no case that has held such a law to be preempted by § 514(a), and we decline to so hold.

As we analyze the issue before us, we are not troubled, as was the district court, by what the plans refer to as the cost shifting aspects of New Jersey's program. The district court accepted the plans' argument that New Jersey was requiring them to act in a manner inconsistent with their obligation under ERISA to apply fund assets only for the benefit of fund participants. Were this the case, New Jersey's statute would, of course, be preempted as applied to the plans. But plaintiffs purport to understand ERISA to impose upon them a burden which would be an intolerable one and which we are confident Congress never intended ERISA plans to bear.

The plans argue that their fiduciary duty to apply fund assets only for the benefit of fund beneficiaries forbids them from paying for hospital services received by those beneficiaries if any portion of the price paid can be viewed as attributable to the cost of providing services to others, such as indigent and Medicare patients. As

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> or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

29 U.S.C. § 1144(c)(2).

[10] The infirmity of this portion of the *Rebaldo* opinion is noted by the Court of Appeals for the Second Circuit in *Smith v. Dunham-Bush, Inc.*, 959 F.2d 6, 9 n. 3 (2d Cir. 1992).

[11] The reasoning of the court in *Rebaldo* parallels that in *Lane v. Goren*, 743 F.2d 1337 (9th Cir. 1984) which held that the application of California's anti-discrimination laws to the employment practices of an ERISA plan's trustees is not preempted by ERISA. The court so held because the California law affected the trustees only in their "capacity as an employer, and in a way that all other employers were affected," *Id.* at 1340, because the only effect was to increase the trustee's costs of doing business. The court noted:

> That argument does not withstand scrutiny. So too, for example, do state law and municipal ordinances regulating zoning, health, and safety increase the operational costs of ERISA trusts, but no one could seriously argue that they are preempted.

See, also, Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 97 n. 17 (1983) (New York's anti-discrimination law as applied to ERISA plans is not preempted "insofar as it prohibits employment discrimination in hiring, promotion, salary, and the like").

the plans appear to us to concede, however, it would be impossible to have a requirement that ERISA plans must "look through" to the pricing structure of every health care provider to assure that the price of the services rendered a particular patient directly correlates with the costs of those services. We think an ERISA plan meets its ERISA responsibilities when it pays whatever portion of the price charged by the health care provider the plan has assumed.

First, the plans do not challenge the base DRG rate feature of New Jersey's price control program even though it is inherent in this approach that a patient having an appendectomy who winds up in intensive care for two weeks pays the same amount as another patient who has an appendectomy and leaves the hospital the following day. The plans do not challenge this aspect of the plan because they acknowledge that it is not feasible in any real sense to isolate the costs attributable to any particular patient. The plans understandably add that if they have enough appendectomy patients over the years the costs they pay on behalf of others theoretically will be offset by the costs other pay on behalf of plan participants. It nevertheless remains true that the portions of the New Jersey scheme unchallenged by the plans recognize the prohibitive transactions costs associated with matching any particular disbursement of fund assets to cover a hospital bill with the actual costs of treating that particular patient.

More importantly, there are many forms of state regulation under the police power which result in increases in the cost of doing business and corresponding increases in prices where the beneficiaries of the regulation are not those who are paying the increased prices. States have recently begun to regulate the disposal of medical wastes, for example, in order to protect those who otherwise would be adversely affected by socially irresponsible disposal. Such regulations can significantly increase a hospital's cost of doing business and, accordingly, its billings to plan participants. We are confident, however, that ERISA was not intended to foreclose a state regulation of this kind. New Jersey's decisions to require hospitals to treat indigents and to treat Medicare patients for the Medicare reimbursement seem to us to be similar exercises of its police power.

In short, we are unwilling to attribute to Congress and §514 an intent to frustrate the efforts of a state, under its police power, to regulate health care costs. In particular, we are unwilling to infer

from ERISA's prohibition against applying fund assets for the benefit of others a Congressional intent to foreclose health care cost regulation of the kind here challenged.

V.

Having concluded that the challenged portions of Chapter 83 are not preempted by § 514(a) and are not unconstitutional, we will reverse the judgment of the district court, vacate the injunction, and remand with instructions that judgment be entered for the defendants.[12]

NYGAARD, *Circuit Judge*, dissenting.

This is a close case because it tests the outer limits of ERISA preemption. Although my decision is made more difficult because the New Jersey regulatory scheme (the "Act") is admirable for its intended purpose and goals, I think Congress intended to preempt these kinds of statutes. The issue is: Whether a statute of purported general applicability "relates to," in the ordinary and broad sense of that term, ERISA plans if it disproportionately impacts upon ERISA plans, presupposes the existence of ERISA plans, and depends on funds extracted from ERISA plans to implement its legislative mandate. Because I believe that the district court correctly concluded that such a statute is preempted, see *United Wire, Metal & Machine Health and Welfare Fund v. Morristown Memorial Hosp.*, 793 F.Supp. 524, 531-37 (D.N.J. 1992), I respectfully dissent.

I.

Congress enacted ERISA to subject employee benefit plans to a uniform system of federal laws governing disclosure, reporting, standards of conduct, remedies, sanctions, and access to federal courts. Since uniformity cannot be achieved if ERISA plans are subject to varying state regulations, Congress preempted "any and all State laws insofar as they . . . *relate to* any employee benefit plans." ERISA § 514(a), 29 U.S.C. § 1144(a) (emphasis added).

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[12] It appears that there are plaintiff plans which have not asserted a claim for restitution. As to any such plaintiff, the passage of the new statute rendered its case moot. The district court should dismiss the claims of any such plaintiffs before entering judgment for the defendants on the remaining claims.

Section 514(a) is deliberately expansive and "conspicuous for its breadth." *FMC Corp. v. Holliday*, 498 U.S. 52, 111 S.Ct. 403, 407 (1990). It is "virtually unique" among federal preemption statutes, *Franchise Tax Bd. v. Construction Laborers Vacation Trust*, 463 U.S. 1, 24 n.26, 103 S.Ct. 2841, 2854 n.26, as it is "one of the broadest preemption clauses ever enacted by Congress." *Evans v. Safeco Life Ins. Co.*, 916 F.2d 1437, 1439 (9th Cir. 1990).

The term "relate to" must be given a "broad common-sense meaning." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 107 S.Ct. 1549, 1553 (1987). A state law relates to an ERISA plan "in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 103 S.Ct. 2890, 2900 (1983). Any connection may trigger preemption, and preemption is not limited to laws relating to the specific subjects covered by ERISA. *Pilot Life*, 481 U.S. at 47-48; *Shaw*, 103 S.Ct. at 2900. That a state law may be "consistent with ERISA's substantive requirements" or was enacted to "effectuate ERISA's underlying purposes" does not save it from preemption. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 105 S.Ct. 2380, 2388-89 (1985); *Mackey v. Lanier Collection Agency & Serv.*, 486 U.S. 825, 108 S.Ct. 2182, 2185 (1988). A state law may relate to a benefit plan even if it is not specifically designed to affect such plans, or its effect is only indirect. *Pilot Life*, 107 S.Ct. at 1552-53; *Shaw*, 103 S.Ct. at 2900; *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 101 S.Ct. 1895, 1907 (1981); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 111 S.Ct. 478, 483 (1990).

Since no law exists in a vacuum and arguably many laws could be held to "relate to" ERISA plans, without some limits Section 514(a) could become a legal blackhole with an attractive force no state law could resist. Hence, some laws are said to affect ERISA plans in "too tenuous, remote, or peripheral a manner to warrant a finding that [they] relate to' the plan." *Shaw*, 103 S.Ct. at 2901 n.21. *See, e.g., Mackey*, 108 S.Ct. at 2191 (garnishment statute of general applicability is not preempted). The task then is to determine the precise relationship between the Act and ERISA plans. *Mackey*, 108 S.Ct. at 2186.

II.

The declared public policy of the Act is to "contain the rising costs of health care services, and to ensure the financial solvency of hospitals." N.J.S.A. § 26:2H-1. The linchpin in this scheme is the

DRG rate, which is a statistical average of costs incurred by hospitals to perform a particular medical procedure. The DRG is the rate hospitals must bill for particular services. Thus, it functions as both a price cap and an incentive to reduce costs.

The plans do not challenge the validity of the DRG rate scheme, but only attack three surcharge components incorporated into the DRG. They are costs for uncompensated care and bad debts. Medicare cost shifts, and costs related to discounts given to certain payer groups. Only hospital patients, not the general public, pay these costs. The New Jersey scheme is, quite simply, a cost-shifting mechanism whereby those who do not have deep pockets or are favored by the law are given discounts or free services. Since these discounts and services cause state-mandated financial losses to hospitals, the Act remunerates hospitals by shifting these losses through the DRG resulting in additional 19.7% and 7% surcharges in uncompensated and Medicare costs shifts to those with deep pockets — commercial insurers and ERISA plans.

ERISA plans play a critical role in this scheme, to the point where without them it would fall apart. They comprise a major segment of the paying hospital service users who subsidize those favored by the Act. The structure of the scheme indicates in not-so-subtle ways that the New Jersey legislature was well aware of the pivotal role ERISA plans would play in its scheme. Upon pain of not receiving reimbursements for their uncompensated care costs, the Act requires hospitals to screen patients to determine whether they are covered by a commercial insurer or a "union welfare plan." N.J.S.A. § 26:2H-18.31(c)(2). Also, under the appeal policy existing at the time, while individual patients as well as third-party payors could have appealed mistakes in the assignment of a particular DRG, only individual patients could have appealed an assignment of a DRG that was technically correct but may have been excessive. "The third-party payer (commercial insurer, *self-funded union*, etc.)" was specifically excluded from appealing a correct but excessive charge. A vast majority of appeals, about 85%, were based on excessive charges, and only about 1% of them were denied. Thus, the goal is transparent and little explanation is needed to see what this appeal process was designed to do.

In October 1990, the New Jersey Governor's Commission on Health Care Cost submitted a report that plainly concluded: "Only a portion of New Jersey businesses, those who purchase insurance for their workers, pay the lion's share of caring for the uninsured." It

summarized the impact on employee benefit plans: "It was apparent that rapidly rising health insurance costs were a significant burden to both the business community and the labor force in this State with the potential to negatively affect New Jersey citizens . . . that the Uncompensated Care Trust Fund while affording access to hospital services was unfairly financed on the backs of those who had health insurance . . . ."

Last, the State concedes that the scheme is not "viable"without money from the plans as they "represent a major segment of the bill-paying public, to the point that it is *impossible* to devise a viable hospital rate-setting scheme if that segment is excluded or exempted from the scheme." Br. 2 (emphasis added). This concession dispels any doubt that the effect of the Act is to reach into the deep pockets of ERISA funds.

The Act provides a conduit by which money is transferred from, among others, ERISA plans to hospitals. Rather than spend its own general funds, New Jersey implemented a money transfer scheme where ERISA plans subsidize the medical bills of those who are favored by law. One affidavit accurately concluded: "Indeed, if the State of New Jersey were to assume the uncompensated care and the Medicare cost shift as social obligations from its general revenues, for example, the average hospital bill would decrease on a pro rata basis by this amount and these shifts would no longer be reflected in New Jersey hospital bills."

III.

The majority believes that the connection between the Act and ERISA plans is too tenuous and remote "[b]ecause we are here dealing with a statute of general applicability that is designed to establish the prices to be paid for hospital services, which does not single out ERISA plans for special treatment, and which functions without regard to the existence of such plans . . . ."Majority typescript at 27. The majority relies in part on *Mackey v. Lanier Collection Agency & Serv., 108* S.Ct. 2182 (1988), to suggest that where there is no direct nexus, or where a statute does not directly affect the administration of ERISA plans, the statute is not preempted despite any "indirect ultimate effect of increasing plan costs." Majority typescript at 29.

In *Mackey* the issue was whether a generally applicable Georgia garnishment statute was preempted by ERISA. The Court first recognized that a statute need not specifically single out, mention, or

have a direct nexus to ERISA plans to be preempted. 108 S.Ct. at 2186, citing *Pilot Life*, 107 S.Ct. at 1552-53, and *Shaw*, 103 S.Ct. at 2900. The Court held, however, that the statute was not preempted. In light of certain ERISA provisions, one of which provides a plan may "sue or be sued" as an entity, 29 U.S.C. § 1132(d)(1), the Court reasoned that money judgments against ERISA plans must be collectable in some way and that garnishment is one permissible method. 108 S.Ct. at 2188 & n.9, citing *FHA v. Burr*, 309 U.S. 242, 60 S.Ct. 488, 491 (1940) (where Congress provides that an entity may "sue or be sued" all civil processes incident to legal proceedings including "garnishment and attachment" may apply). Thus, *Mackey* does not stand for the proposition that a generally applicable statute should not be preempted even though it may result in some "indirect economic impact." It stands for the proposition that where *Congress intended* for state law to apply to ERISA, that law will not be preempted even though it may otherwise relate to ERISA plans by placing indirect financial or administrative burdens on them.[1]

The majority nowhere shows how any provision in or the structure of ERISA suggests that Congress did not intend these kinds of statutes to be preempted. See *Malone v. White Motor Corp.*, 435 U.S. 497, 504 (1978) ("purpose of Congress is the ultimate touchstone"). Where Congress adopts a broad preemption provision, the "task of discerning congressional intent is considerably simplified." *Ingersoll-Rand*, 111 S.Ct. at 482.

Although any connection may suffice, the task is made easier when the statute refers to or specifically singles out ERISA plans. The Act requires hospitals to ask patients whether they belong to a "union welfare plan," and it expressly excludes "self-funded union" plans from appealing hospital bills. The majority, however, brushes these references aside by concluding that they "can be excised without altering the effect of [the]statute in any way," and therefore they "should be regarded as without legal consequence for § 514(a) purposes." Majority typescript at 27 n.6.

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[1] Without the congressional intent derived specifically from the structure of ERISA, *Mackey* would probably have been decided differently. Both the majority and the dissent in *Mackey* observed that the garnishment law subjected the plans to "substantial" and "significant administrative burdens and costs." See 108 S.Ct. at 2186, 2192. Because "plans face the repetitious and costly burden of monitoring controversies involving hundreds of beneficiaries and participants in various States." *Id.* at 2193, Justices Kennedy, Blackmun, O'Conner, and Scalia dissented.

The majority underestimates the significance of these references. New Jersey has implicitly classified all hospital users into two groups: those who are able to pay and those who are not. This simple dichotomy then determines "whether the patient is eligible for participation in a public assistance program," N.J.S.A. § 26:2H-18-31(c)(3), whether one must pay the three surcharges, and whether and what one may appeal. A large segment of the small percentage of patients who are able to fully pay for medical services are plan beneficiaries, and hence New Jersey requires hospitals to ask whether a patient belongs to a "union welfare plan." Thus, the conclusion that the references to ERISA plans in the Act "can be excised without altering the effect of [the] statute in any way" is without support.

Even assuming, arguendo, that the Act does not expressly single out ERISA plans for special treatment, it does so *as applied*. One cannot ignore the practical consequences produced by this statute, a consequence that according to the report commissioned by the State resulted in ERISA plans having paid "the lion's share of caring for the uninsured." See *Mackey*, 108 S.Ct. at 2185 (it is "virtually taken [] for granted that state laws which are 'specifically designed to affect employee benefit plans' are pre-empted under § 514(a)").

Moreover, the assumption that the Act "functions without regard to the existence of such plans" is puzzling in light of the State's concession that the Act is not "viable" without ERISA plans. The Act was designed with ERISA funds in mind. In this sense, it has been eminently successful; the financial drain on ERISA funds has been enormous. The surcharges are paid not by the general public at large, but by the less than 25% of the population who use hospital services. Of those 25%, about 75% receive the uncompensated care assessments challenged here. ERISA plan participants comprise only about 15% of the hospital patients, but pay about 40% of the more than $1.1 billion shortfall generated by the state-mandated cost shifts.

In *Ingersoll-Rand Co. v. McClendon*, 111 S.Ct. 478 (1990), an employee sued in Texas state court, alleging that he was fired because his employer did not want to contribute to his pension fund. He sought damages under various tort and contract theories, but did not plead an ERISA cause of action. The Texas Supreme Court recognized a cause of action for wrongful discharge based upon "the employer's desire to avoid contributing to or paying benefits under the employee's pension fund." The Supreme Court reversed

and held that the cause of action is preempted because it was premised on the existence of a pension plan. It reasoned that "to prevail, a plaintiff must plead, and the court must find, that an ERISA plan exists and the employer had a pension-defeating motive in terminating the employment. Because the court's inquiry must be directed to the plan, this judicially created cause of action 'relates to' an ERISA plan." *Id.* at 483.

Similar to the Texas cause of action, the New Jersey statute is predicated on the existence of ERISA plans and its mandates cannot be carried out without ERISA funds. See *Id.* at 484 ("there simply is *no* cause of action if there is no plan") (emphasis in original). Also, the costs associated with the New Jersey regulatory scheme are not qualitatively the same as those in either *Mackey* or *Ingersoll-Rand*. In *Mackey*, the four dissenting Justices opined that the administrative burdens of allowing ERISA benefits to be garnished were so "significant" as to warrant preemption of a generally applicable garnishment statute. 108 S.Ct. at 2192. In *Ingersoll-Rand,* a unanimous Supreme Court noted that the litigation costs of defending against a cause of action predicated upon the existence of an ERISA plan were substantial. 111 S.Ct. at 483. No one will dispute that these costs pale in comparison to the hundreds of millions of dollars extracted from ERISA funds under the Act. And while the majority may classify these costs as "the limited nature of the statute's impact on such plans," I do not.

One may argue that nothing in the Act establishes the level of benefits or structure plan benefits to include these shifted costs and that each plan is free to cover all, some or none of these costs. This argument is unpersuasive. In *General Elec. Co. v. New York Dep't of Labor*, 891 F.2d 25 (2d Cir. 1989), a New York labor law of general application provided that wages and "supplements" (nonwage benefits which included ERISA plans) on a public works contract must at least equal the prevailing rate and benefits paid in the locality. Where the cost of a benefit provided by an ex-locality contractor did not match those of a similar prevailing local benefit, the statute required the contractor either to bring the benefit into conformity with the local benefit, or to make up the difference through cash payments to its employees. Nothing in the statute, however, required a contractor to alter the benefits to match those in the locality, and the contractor was free to pay cash instead. But the Court of Appeals for the Second Circuit held that ERISA preempted the labor law. It reasoned that the law clearly related to

ERISA plans in that to conform to the statute contractors had to maintain "schedules of supplements and wages and to make its books and records pertaining to wages, supplements and hours of labor available for inspection." *Id.* at 29-30.

The Act is analogous to the New York labor statute because it requires ERISA plans either to pay the surcharges or to restructure their benefits to avoid them. Since no one likes to pay for benefits or services one did not receive or benefit from, it is reasonable to expect that some plans may change their terms to exclude these costs, just as it was reasonable to expect that some New York contractors would restructure ERISA plans instead of paying cash benefits. Implicit, then, is the assumption that an ERISA plan, if it does not want to pay for the direct cost of services provided to nonbeneficiaries, "structure all its benefit payments in accordance with New Jersey [hospital rates], or to adopt different payment formulae for employees inside and outside of the State." See *Fort Halifax*, 107 S.Ct. at 2217; *Alessi*, 101 S.Ct. at 1907. This is the precise reason why Congress enacted such a broad preemption provision: so that employee benefit plans would not be subject to the vagaries of state regulations. *Ingersoll-Rand*, 111 S.Ct. at 484; *Fort Halifax*, 107 S.Ct. at 2217.

Because New Jersey has asked ERISA plans to carry the brunt of the burden of keeping hospitals financially afloat and, in fact, to largely subsidize its venture into hospital price regulation, and because the State admits that result before this court, I agree with the district court's conclusion that there is a definite, palpable connection between the Act and the plan. See *United Wire*, 793 F.Supp. at 531-37.

IV.

Much attention in this appeal has been focused on *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984). The New York statute provided that the state must establish for each hospital an "inpatient revenue cap," which was a price cap with additional allowances made for bad debts and charity care. The statute allowed certain programs, like Blue Cross, to get discounts, but certain ERISA plans did not qualify. The Court of Appeals for the Second Circuit first reasoned that because Section 514(c)(2) defines "State" as any agency, instrumentality or political subdivision that "purports to

regulate, directly or indirectly, the terms and conditions of employee benefit plans." 29 U.S.C. § 1144(c)(2), this restriction modifies Section 514(a)'s broad preemption provision. 749 F.2d at 137. The court held that where "a State statute of general application does not affect the structure, the administration, or the type of benefits provided by an ERISA plan, the mere fact that the statute has some economic impact on the plan does not require that the statute be invalidated." *Id.* at 139. This holding is now infirm as the Supreme Court has since rejected the view that the definition of "State" restricts the scope of Section 514(a). *Ingersoll-Rand*, 111 S.Ct. at 484.[2]

The *Rebaldo* court justified its holding with an economic/policy argument. It reasoned that the regulation of hospital rates are analogous to any state regulations that increase the cost of doing business for hospitals. 749 F.2d at 138. Thus, for example, the court opined that ERISA plans could not contend that they are exempt from price increases as a result of increased labor, utility, or rent costs, or from such minor costs as the bridge and tunnel tolls that are charged to plan officers or employees. *Id.* Moreover, it opined that since ERISA plans can be subject to nationally uniform supervision despite dissimilarities in hospital prices, any "indirect economic impact" would be consistent with ERISA's aim of national uniformity in plan regulation. *Id.* at 139.

Recently, even this economic rationale, for whatever worth it had, has been eroded. Although the *Rebaldo* court suggested that "State labor laws that govern working conditions and labor costs . . . that [have] some economic impact on the plan"would not be preempted, *id.* at 138-39, the Court of Appeals for the Second Circuit has since retreated from this position and has preempted a generally applicable statute governing labor costs that imposed upon ERISA plans indirect financial and administrative burdens. *General Electric*, 891 F.2d at 29-30.[3]

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[2] Although the majority recognizes that *Ingersoll-Rand* overruled *Rebaldo*, at least in part, it distinguishes *Ingersoll-Rand* on the basis that the *Rebaldo* court dealt with "'a generally applicable statute that makes no reference to, [and] functions irrespective of, the existence of an ERISA plan.'" Majority typescript at 32, quoting *Ingersoll-Rand*, 111 S.Ct. at 483. Of course, that is the question here.

[3] Indeed, although Judge Van Graafeiland authored both *Rebaldo* and *General Electric*, the dissent in *General Electric* considered *Rebaldo* controlling:

> The majority does not attempt to distinguish *Rebaldo* and *Aetna Life* nor, in my view, could it sensibly do so. Like the statutes we upheld in those decisions, New York's prevailing wage statute is a law of general application

Despite the Supreme Court's rejection of the holding in *Rebaldo* and the Court of Appeals for the Second Circuit's implicit rejection of what appears to be the rest, the majority nonetheless relies heavily on it. Faced with Section 514(a)'s sweeping preemption provision and the cause-and-effect financial connection between the Act and ERISA funds, the majority justifies its decision by reasoning that the Act is analogous to any number of state laws that may indirectly increase the cost of doing business, such as regulations governing labor, utility, or rent costs. Majority typescript at 29. It suggests as an example that regulations concerning the disposal of medical waste would not be preempted though their implementation may net higher medical bills as a result of the increased cost of doing business. *Id.* at 33.

I agree with the majority insofar as ERISA plans do not lead a "charmed existence." *Rebaldo*, 749 F.2d at 139. They are, of course, not exempt from paying rent, tolls, or even the many overhead costs associated with hospital management. The DRG takes into account both direct costs, such as hospital employees' salaries and benefits, and indirect costs, such as institutional overhead expenses for management, research, education and maintenance. The plans, however, do not argue that the *entire* DRG system is incompatible with ERISA; they do not argue that they must only pay the "actual costs" for medical services; they do not argue that any laws that increase the cost of doing business for hospitals do not apply to them; nor do they argue that they are entitled to pay to the penny only their pro rata share of overhead and incidental costs. They argue instead that the three surcharges differ from ordinary overhead costs in two important ways: first, plan participants derive no benefit from these surcharges; second, these surcharges are not equitably distributed to the general population, or to the State, or to even hospital users, but are placed squarely on the shoulders of commercial insurers and ERISA plans. As a result, they contend

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> whose tangential effects on employee benefits plans are negligible and wholly incidental to the law's primary purpose.

891 F.2d at 31.

The rejection of *Rebaldo* is understandable. It is not so much attributable to inconsistent decision making as to the court's recognition that ERISA preemption is as broad as the statute would suggest. The Court of Appeals for the Second Circuit decided *Rebaldo* in 1984, without the benefit of, among other cases. *Holliday*, *Pilot Life*, *Metropolitan Life*, *Mackey*, and *Ingersoll-Rand*

that they are forced to subsidize nonparticipant patients with ERISA funds.

The majority largely ignores these distinctions, choosing instead to sweep all state-mandated costs under the general penumbra of "overhead" costs. When states regulate, for example, utility, labor, education or medical sanitation, they increase the cost of doing business. To remain solvent and be able to provide services, businesses must be able to incorporate into prices these increases. In a market-based system, each consumer will pay for costs attributable to running the business, so overhead is part of the indirect costs associated with the purchase of goods and services. Since it is administratively impossible to isolate the precise actual costs attributable to any particular patient, many of the direct and indirect costs incorporated into the DRG such as overhead for management and maintenance are proper. The plans do not contend otherwise.

The surcharges are a different story, however. They are not indirect costs associated with *any* hospital services to plan beneficiaries. They are the direct cost of hospital services rendered to *other patients*, which have then been shifted to ERISA plans. One can argue, as the appellants do, that even businesses incorporate losses involved in stolen merchandises and bad debts into their prices. But the issue is not whether ERISA protects plans from the imposition of these kinds of costs because ERISA preempts only "state law" and not private action, or whether ERISA plans are entitled to nationally uniform hospital prices because that is impossible. The issue is whether state regulations have interfered with the operation of ERISA plans to the point where the plans have suffered large financial losses.

The argument that plans are affected the same way without regulations is based on questionable applications of economic assumptions. In a free market system, as well as most regulated systems, no business would knowingly sell to one who cannot in full or in part pay, whereas here New Jersey requires hospitals to provide services regardless of the ability to pay and then places the losses squarely on a small class of patients. Without the Act, the financial calculus and its effects on ERISA funds would change drastically. Since each hospital will have different rates depending in part upon their total losses, with urban hospitals, for example, incurring more losses from indigent care and bad debts, the plans would be free to select hospitals with the lowest prices. And even if hospitals distribute their losses by overcharging ERISA plans, the plans would

have an alternative: they would normally be free to negotiate with various hospitals for group rates just as some groups under the Act are able to negotiate lower rates (the difference of which ERISA funds have been forced to defray). Under the Act, however, the plans are in effect precluded from negotiating group rates because, as the State concedes, the Act takes away any incentive to negotiate when it prohibits hospitals from passing on to other patients any revenue shortfall caused by a digression from the DRG rates. But see Majority typescript at 29-30 ("Nor does [the Act] deprive ERISA plans of any alternative they would otherwise have in these areas.").

Moreover, in both market-based and regulated systems, businesses generally pass losses to *all* customers. Here, the object of the Act is to pass hospital losses inequitably to a small segment of hospital consumers. The surcharges are neither paid by the State nor the public at large; they are not even paid by all hospital users. The State created these surcharges with the specific intention that, in essence, only a small group of the hospital users — a large majority of whom comprise ERISA beneficiaries — would pay for them. While the plans do not derive *any* benefit, real or abstract, from the surcharges, the Act takes a substantial chunk of money belonging to ERISA beneficiaries, and all because New Jersey does not want to expend its general funds to pay for the health care costs of others who are less fortunate. As one affidavit summarized: "In effect, New Jersey requires the hospitals to give the service but will pay for it using other people's money, i.e., other users of the hospitals rather than a broader base revenue source such as general taxation."

Thus, the surcharges here are anything but "ordinary" overhead costs that indirectly increase the cost of doing business, and the argument that the Act simply sets prices does not sufficiently credit the direct financial impact on ERISA plans. The majority is correct insofar as states may regulate, for example, the disposal of medical waste and allow hospitals to pass these costs off to patients; but if states require hospitals to pass off these costs only or largely to "commercial insurers and self-funded union plans," such regulations must be preempted.

V.

I fear that the majority gives States free reign to spend and experiment with ERISA funds, held in trust for the many workers who

have labored long for their security, in the noble pursuit of health care reforms so long as States exercise a minimum degree of imagination by couching their statutes in "generally applicable" terms. When I consider the financial impact and other causal effect on ERISA funds in a common sense manner, the connection between ERISA plans and the Act is not too tenuous, remote or peripheral at all. The Act refers specifically to ERISA plans, divests enormous sums of money from ERISA plans, and is predicated on the existence of ERISA plans. In my opinion the Act "relates to" ERISA plans when that term is construed in its ordinary and broad meaning, and I dissent.

A True Copy:

Teste:

Clerk of the United States Court of Appeals
for the Third Circuit

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

Nos. 92-5317/5319/5320/
5341/5343/5345/5352/5354/5355

UNITED WIRE, METAL AND MACHINE HEALTH AND WELFARE FUND; JACK STOLL; ESTHER BORJA; JAVIER RESTREPO; UNITED FOOD AND COMMERCIAL WORKERS INTERNATIONAL UNION LOCAL 464A, AFL-CIO GROUP REIMBURSEMENT WELFARE PLAN; FRANK LACATENA; DOLORES LACATENA; NEW JERSEY CARPENTERS WELFARE FUND; LOCAL #807 LABOR-MANAGEMENT HEALTH FUND; TRUSTEES OF THE LOCAL #807 LABOR-MANAGEMENT HEALTH FUND; PROSPER ALEXANDER; MARIE ALEXANDER; DISTRICT COUNCIL OF IRONWORKERS OF NORTHERN NEW JERSEY WELFARE FUND; ARCHIE G. FERGUSON; RONALD W. JENSEN; JOHN J. IRVINE; WALTER PHILLIPS; MICHAEL J. MCDERMOTT; SAMUEL PACICH; ALBERT J. IRWIN; NICHOLAS J. ANDRETTA, SR.; GARY UGARO; WALTER F. STEINMETZ; JOHN D. MULVANY; MICHAEL W. FEATHERSON; FRANCIS E. ARNY; JOHN J. CLARK, SR.; RONALD W. WILLIAMS; DANIEL J. PEREZ; KEITH E. ZDEP; EDWARD WEIDLER; LOUIS ROCCO; RAYMOND J. RODGERS; FRANCIS J. AKESSON; DONALD J. BANTA, SR.; CHARLES W. BIRD; DAVID F. BROWN; CLIFFORD CROOKS; ROBERT T. CUSICK; JAMES P. FITZGERALD; JOSEPH A. FUSARO; CHARLES GAMBA; RICHARD GOUGEON; JOHN KEATING; GERARD MCCLOUD; ROBERT MCGEE; ALEXANDER MCLELLAN; JOHN MURPHY; LAURENCE O'BRIEN; PETER O'CONNER; RAUL RODRIGUEZ; ROBERT SCHWEITZER; ROBERT SICKLES; ANDREW L. SMITH; RICHARD SPARKS; GEORGE SUDAK; EDWARD TEDESCO; JAMES TOAL; ENOCH P. MCMAHON; LOCAL UNION 400; IBEW WELFARE FUND;

BRIAN HRUSKA; WILLIAM MARSH; CHARLES WORK; HAROLD RUTLEDGE; RALPH ALLEN; THOMAS VADAS; VINCENT WORTH; TIMOTHY HILL; RONALD RAMSEY; JOHN IRELAND; JAMES MARTIN; MICHAEL ALMASI; BEVERLY A. RUBY; PETER NAMOTKA; DANIEL KENNEDY; GEORGE COLE; WALTER DAVIES; ROBERT HERMANN; FRANK HERMANN; CHARLES KELLER; DENNIS JOHNSON; CONNIE J. KOEHLER; FRANK O'DAY; VINCENT LA STELLA; DONALD MCNEIL; JEAN-LOUIS POULIOT; NICHOLAS AEMISEGO; ROBERT STAHNKE; PHILIP CERZA; GARY GIORGIO; EDWARD OSOWSKI; GLENN HALVORSEN; WILLIAM STADELMAN; DANIEL JULIO, JR.; FRANCIS ALEXANDER; LEONARD DAHL; MICHAEL DEVINE; JOSEPH GEORGE; RALPH JENSEN; DONALD LA BRUTTO; NORMAN GRAMLICH; JUAN ROMERO; JOSEPH PIWOSKI; HARRY PEASE, JR.; EUGENE O'ROURKE; PAUL NIEDZINSKI; BERNARD WALL; STEPHEN KOJAC; CHARLES KRUPKA; WILLIAM MCCORMACK; MINOR KENNARD; STEPHEN J. SANGLE; DONALD SCHIRALDO; JOHN GACINA, III; BRIAN MCCARTHY; CHARLES MCNALLY; ROBERT CZAJOWSKI; BRIAN WOODALL; JEFFREY STAHNKE; JOHN RYAN; RALPH ROSAMILIA, SR.; DANIEL MUGAN; EDWARD MIRONSKI; MICHAEL MIDDINGS; ANDREW MAHASKY; WALTER JELINSKY; ALBERT GAECHTER; LOUIS DI MASCIO; ELLIOTT ROSEMAN; TRUSTEES OF THE OPERATING ENGINEERS LOCAL 825 WELFARE FUND; RICHARD HORNECKER; TEAMSTERS LOCAL 11 BENEFIT PLAN; TRUSTEES OF THE TEAMSTERS LOCAL 11 BENEFIT PLAN; KATLUSKA BAIDAL; WILLIAM BARTEL; GUNTER BLOHM; ANGELO BUINNO; BETTY J. CAIRNS; FRANK CLOSE; JOSE CRUZ; SANTOS GARCIA; KAREN GENSURE; DOROTHY LARSON; RICHARD LITCHFIELD; SANDRA MARINO; JOHN MATUSZKIEWICZ; GEORGE MCCLAUGHLIN; OLGA MONTES; FERNANDO PEREZ; SANTO RAMOS; MARTHA SARA; ROXEEN SCALA; EDMUND SCOTT; CHARLIE TAYLOR; MELISSA TURI, SANGPO TSULDIN; COSMO VISENTINI; NYSA-ILA WELFARE FUND; JOHN BOWERS; ALBERT CERNADAS; FRANK LONARDO; THOMAS POPOLA; JAMES CAPO; JOSEPH N. BARBERA; BART DIMATTINA; RICHARD H.

O'NEILL; LABORERS INTERNATIONAL UNION OF NORTH AMERICA LOCAL 415 HEALTH AND WELFARE FUND; SHEET METAL WORKERS LOCAL UNION NO. 25 WELFARE FUND; JEFFREY STAJEK; JAMES LUCIANO; JOHN A. FREUDENREICH, SR.; THOMAS SMIECH; JOSEPH MCCALLION; DANIEL SMITH, JR.; JAMES MCKAY; MARK COX; TRUSTEES OF THE TEAMSTERS LOCAL 641 WELFARE FUND; CARLOS ROCHA; GEORGE KOESTER; CARMELA FERENS; KHOONRAJIE RAGHUBANS; PHILLIP SAVITTIERI; EAR PATTERSON; ROBERT REEDER; LOCAL 1245, LOCAL 1245 HEALTH FUND; ANTHONY RIZZO; JOSEPH ABBATE; JOSEPH MASSOUD; RALPH MASTRANGELO; TRUSTEES OF THE WELFARE TRUST FUND, LOCAL UNION NO. 475; WILLIE A. BARNES; HERMAN GEIGER; VINSTON LEE KING; KEVIN E. KLINE; ROBERT L. ROSA; WILLIAM BRENNAN; JAMES MURPHY, JR.; PATRICIA MCELLIGOTT; KEVIN MCCORMICK; PATRICK RYAN, JR.; ANTHONY E. SMITH; ROBERT LAVERATT; JOHN S. WITTEK; JOHN MCQUILKEN; JOHN MONTESANO; ROY E. FRANK; JOHN O'NEILL, JR.; FRANK ROBINSON; DALE SCHAEFER; JOHN J. SERRA; DONALD SHERIDAN; WENCESLAO SOTO; MICHAEL J. RUSSO; JOSEPH P. MURPHY, JR.; CALVIN R. SUTTON, III; RONALD J. ZAKARZEWSKI; FRANK WHITNEY, SR.; JACK NACHTIGALL; LAWRENCE PARKIN; EDISON RODRIQUEZ; WILLIAM MORAN; VINCENT DOFFONT; GEORGE STOUT; BRIAN LUBECK; AMERICO GUGLIELMO; DAVID VADAS; CHRISTOPHER ANDREWSKI; DAVID JENKINS; ARTHUR ACKERMAN; KENNETH FINTON; RAMON LORENZO; WESLEY SANDERSON; CHARLES NEWMAN, III; LEONARD IAROSSI; GEORGE ROSSI; WILLIAM SKIECZIUS; JOHN HANCOCK; EDWARD THORNE; JOSEPH TAGLIADIA; MICHAEL MACHANSKA; STEVE PARLACASK

v.

MORRISTOWN MEMORIAL HOSPITAL; FRANCES J. DUNSTON; NEW JERSEY COMMISSIONER OF HEALTH; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; NEW JERSEY COMMISSIONER OF HEALTH; FRANCES DUNSTON; MEMORIAL HOSPITAL OF BURLINGTON COUNTY; THE MEDICAL CENTER OF OCEAN COUNTY;

KIMBALL MEDICAL CENTER; MERCER MEDICAL CENTER; OUR LADY OF LOURDES HOSPITAL; PRINCETON MEDICAL CENTER; HOSPITAL OF SALEM COUNTY; NEWCOMB MEDICAL CENTER; RIVERVIEW MEDICAL CENTER; COMMUNITY MEDICAL CENTER; SHORE MEMORIAL HOSPITAL; BURDETTE TOMLIN MEMORIAL HOSPITAL; CHRIST HOSPITAL; NEWARK BETH ISRAEL MEDICAL CENTER; ST. JOSEPH'S HOSPITAL; WAYNE GENERAL HOSPITAL; SOUTH JERSEY HOSPITAL SYSTEM; COOPER HOSPITAL; WEST JERSEY HEALTH SYSTEMS; ATLANTIC CITY MEDICAL CENTER; UNION MEMORIAL HOSPITAL; ELIZABETH GENERAL HOSPITAL; ENGLEWOOD HOSPITAL; ROBERT WOOD JOHNSON UNIVERSITY HOSPITAL; BARNERT MEMORIAL HOSPITAL; PASSAIC GENERAL HOSPITAL; RAHWAY HOSPITAL; VALLEY HOSPITAL; HOLY NAME HOSPITAL; ST. PETER'S MEDICAL CENTER; SOMERSET MEDICAL CENTER; OVERLOOK HOSPITAL; ST. ELIZABETH HOSPITAL; DOVER GENERAL MEDICAL CENTER; HUNTERDON MEDICAL CENTER; CHILTON MEMORIAL HOSPITAL; KESSLER MEMORIAL HOSPITAL; FREEHOLD AREA HOSP.; KENNEDY MEMORIAL HOSPITAL; UNIVERSITY HOSPITAL; UNDERWOOD MEMORIAL HOSPITAL; JERSEY CITY MEDICAL CENTER; ST. JOSEPH'S HOSPITAL; ST. BARNABAS MEDICAL CENTER; RARITAN BAY MEDICAL CENTER; CLARA MAASS MEDICAL CENTER; ST. CLARES/RIVERSIDE MEDICAL CENTER; JOHN F. KENNEDY MEDICAL CENTER; HACKETTSTOWN COMMUNITY HOSPITAL; ZURBRUGG MEMORIAL HOSPITAL; JERSEY SHORE MEDICAL CENTER; MONMOUTH MEDICAL CTR; NEWTON MEMORIAL HOSPITAL; UNIVERSITY OF MEDICINE & DENTISTRY OF NEW JERSEY; DEBORAH HEART AND LUNG CENTER; HOSPITAL CENTER AT ORANGE; DOVER GENERAL HOSPITAL; WEST JERSEY HEALTH SYSTEM; RARITAN BAY MEDICAL CENTER; HACKENSACK MEDICAL CENTER; SOUTH AMBOY MEMORIAL HOSPITAL; THE MOUNTAINSIDE HOSPITAL; ST. FRANCIS HOSPITAL; BAYONNE HOSPITAL; MUHLENBERG HOSPITAL; CENTRASTATE (FAH) HOSPITAL, ST. JAMES HOSPITAL; KENNEDY MEMORIAL HOSPITAL AT SADDLE

BROOK; ADMINISTRATOR OF THE NEW JERSEY HEALTH CARE TRUST FUND; NEW JERSEY DEPARTMENT OF HUMAN SERVICES (DIVISION) OF MEDICAL ASSISTANCE AND HEALTH SERVICES; ELIZABETH GENERAL MEDICAL CENTER; DOVER GENERAL MEDICAL CENTER; IRVINGTON GENERAL HOSPITAL; UNION HOSPITAL; WARREN HOSPITAL, COLUMBUS HOSPITAL; EAST ORANGE GENERAL HOSPITAL, FRANCIS DUBEAU; LILLIAN DUBEAU; BAYSHORE COMMUNITY HOSPITAL; NEW JERSEY HOSPITAL ASSOCIATION; BERGEN PINES COUNTY HOSPITAL; COMMUNITY MEMORIAL HOSPITAL; GREENVILLE HOSPITAL; MONTCLAIR COMMUNITY (HOSPITAL) PALISADES GENERAL HOSPITAL; PASSAIC BETH ISRAEL HOSPITAL; RARITAN BAY MEDICAL CENTER/PERTH AMBOY DIVISION; RIVERVIEW MEDICAL CENTER; SOUTHERN OCEAN COUNTY HOSPITAL; ST. MARY'S HOSPITAL; THE GENERAL HOSPITAL CENTER AT PASSAIC; WALLKILL VALLEY HOSPITAL AND HEALTH CENTERS; ST. MARY'S HOSPITAL (PASSAIC); UNITED HOSPITAL; PASCACK VALLEY HOSPITAL; WEST HUDSON HOSPITAL; JOHNSON UNIVERSITY HOSPITAL; ADMINISTRATOR OF THE NEW JERSEY HEALTH CARE TRUST FUND; NEW JERSEY DEPARTMENT OF HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES; NEW JERSEY HOSPITAL; NEW JERSEY HOSPITAL ASSOCIATION,

Intervenor-Defendants

(Newark New Jersey District Consolidated Lead Civil No. 90-02639)

UNITED WIRE, METAL AND MACHINE HEALTH AND WELFARE FUND; ESTHER BORJA

v.

ST. MARY'S HOSPITAL HOSPITAL; NEW JERSEY COMMISSIONER OF HEALTH; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; FRANCES J. DUNSTON;

(Newark New Jersey District Civil No. 90-03640)

UNITED WIRE, METAL AND MACHINE HEALTH AND WELFARE FUND; JAVIER RESTREPO

v.

ST. JOSEPH'S HOSPITAL AND MEDICAL CENTER; FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION

(Newark New Jersey District Civil No. 91-00073)

UNITED FOOD AND COMMERCIAL WORKERS INTERNATIONAL UNION, LOCAL 464A, AFL-CIO GROUP REIMBURSEMENT WELFARE PLAN; FRANK LACATENA; DOLORES LACATENA

v.

WAYNE GENERAL HOSPITAL; FRANCES J. DUNSTON; NEW JERSEY COMMISSIONER OF HEALTH; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION

(Newark New Jersey District Civil No. 91-00336)

DISTRICT COUNCIL OF IRONWORKERS OF NORTHERN NEW JERSEY WELFARE FUND; ARCHIE G. FERGUSON; RONALD W. JENSEN; JOHN J. IRVINE, WALTER PHILLIPS; MICHAEL J. MCDERMOTT; SAMUEL PACICH; ALBERT J. IRWIN, NICHOLAS J. ANDRETTA, SR.; GARY UGARO; WALTER F. STEINMETZ; JOHN D. MULVANEY; MICHAEL W. FEATHERSON; FRANCIS E. ARNY; JOHN J. CLARK, SR.; RONALD W. WILLIAMS; DANIEL J. PEREZ; KEITH E. ZDEP; EDWARD WEIDLER; LOUIS ROCCO; RAYMOND J. RODGERS; FRANCIS J. AKESSON; DONALD J. BANTA, SR; CHARLES W. BIRD; DAVID BROWN; CLIFFORD CROOKS; ROBERT T. CUSICK; JAMES P. FITZGERALD; JOSEPH A. FUSARO; CHARLES GAMBA; RICHARD GOUGEON; JOHN KEATING; GERARD MCCLOUD; ROBERT MCGEE; ALEXANDER MCLELLAN; JOHN MURPHY; LAURENCE O'BRIEN; PETER O'CONNER; RAUL RODRIGUEZ; ROBERT SCHWEITZER; ROBERT SICKLES; ANDREW L. SMITH;

RICHARD SPARKS; GEORGE SUDAK; EDWARD TEDESCO; JAMES TOAL; ENOCH P. MCMAHAN

v.

FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; DEBORAH HEART AND LUNG CENTER; HUNTERDON MEDICAL CENTER; ST. FRANCIS HOSPITAL; HOSPITAL CENTER AT ORANGE; ST. PETERS MEDICAL CENTER; ST. CLARES/RIVERSIDE MEDICAL CENTER; JOHN F. KENNEDY MEDICAL CENTER; DOVER GENERAL HOSPITAL; ST. BARNABAS MEDICAL CENTER; VALLEY HOSPITAL; OVERLOOK HOSPITAL; RAHWAY HOSPITAL; NEWTON MEMORIAL HOSPITAL; WEST JERSEY HEALTH SYSTEM; RARITAN BAY MEDICAL CENTER; HACKENSACK MEDICAL CENTER; CLARA MAASS MEDICAL CENTER; HOLY NAME HOSPITAL; NEWARK BETH ISRAEL MEDICAL CENTER; BAYONNE HOSPITAL; CHILTON MEMORIAL HOSPITAL; ST. JOSEPH'S HOSPITAL; MUHLENBERG HOSPITAL; COMMUNITY MED CENTER; CHRIST HOSPITAL; SOUTH AMBOY MEMORIAL HOSPITAL; CENTRASTATE (FAH) HOSPITAL; WAYNE GENERAL HOSPITAL; PRINCETON MEDICAL CENTER; ST. JAMES HOSPITAL,a/k/a CATHEDRAL HEALTH SERVICES, INC.; MOUNTAINSIDE HOSPITAL; PASSAIC GENERAL HOSPITAL; NEW JERSEY HOSPITAL ASSOCIATION

Intervenor/Defendant

(Newark New Jersey District Civil No. 91-02190)

NEW JERSEY CARPENTERS WELFARE FUND

v.

FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; SOUTH JERSEY HOSPITAL SYSTEM; COOPER HOSPITAL; WEST JERSEY HEALTH SYSTEMS; ATLANTIC CITY MEDICAL CENTER; MEMORIAL HOSPITAL OF BURLINGTON COUNTY; THE MEDICAL CENTER OF OCEAN COUNTY; KIMBALL MEDICAL CENTER; MERCER MEDICAL CENTER; OUR LADY OF

LOURDES; PRINCETON MEDICAL CENTER; HOSPITAL OF SALEM COUNTY; NEWCOMB MEDICAL CENTER; RIVERVIEW MEDICAL CENTER; COMMUNITY MEDICAL CENTER; SHORE MEMORIAL HOSPITAL; BURDETTE TOMLIN MEMORIAL; CHRIST HOSPITAL; MORRISTOWN MEMORIAL HOSPITAL; NEWARK BETH ISRAEL MEDICAL CENTER; WAYNE GENERAL HOSPITAL; UNION MEMORIAL HOSPITAL; ELIZABETH GENERAL HOSPITAL; ENGLEWOOD HOSPITAL, ROBERT WOOD JOHNSON UNIVERSITY HOSPITAL; BARNERT MEMORIAL HOSPITAL; PASSAIC GENERAL HOSPITAL; RAHWAY HOSPITAL; THE VALLEY HOSPITAL; HOLY NAME HOSPITAL; ST. PETER'S MEDICAL CENTER; SOMERSET MEDICAL CENTER; OVERLOOK HOSPITAL; ST. ELIZABETH HOSPITAL; DOVER GENERAL MEDICAL CENTER; HUNTERDON MEDICAL CENTER; CHILTON MEMORIAL HOSPITAL; KESSLER MEMORIAL HOSPITAL; FREEHOLD AREA HOSPITAL; KENNEDY MEMORIAL HOSPITAL; UNIVERSITY HOSPITAL; UNDERWOOD MEMORIAL HOSPITAL; JERSEY CITY MEDICAL CENTER; ST. JOSEPH'S HOSPITAL; ST. BARNABAS MEDICAL CENTER; RARITAN BAY MEDICAL CENTER; CLARA MAASS MEDICAL CENTER; ST. CLARE'S/RIVERSIDE MEDICAL CENTER; JOHN F. KENNEDY MEDICAL CENTER; HACKETTSTOWN COMMUNITY HOSPITAL; ZURBRUGG MEMORIAL HOSPITAL; JERSEY SHORE MEDICAL CENTER; MONMOUTH MEDICAL CENTER; NEWTON MEMORIAL HOSPITAL; NEW JERSEY HOSPITAL, NEW JERSEY HOSPITAL ASSOCIATION

Intervenor/Defendant

(Newark New Jersey District Civil No. 91-03280)

LOCAL #807 LABOR-MANAGEMENT HEALTH FUND; TRUSTEES OF THE LOCAL #807 LABOR-MANAGEMENT HEALTH FUND; PROSPER ALEXANDER; MARIE ALEXANDER

v.

UNIVERSITY HOSPITAL; UNIVERSITY OF MEDICINE & DENTISTRY OF NEW JERSEY; FRANCES J. DUNSTON, in

her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION

(Newark New Jersey District Civil No. 91-03286)

LOCAL UNION 400, IBEW WELFARE FUND; BRIAN HRUSKA; WILLIAM MARSH; CHARLES WORK; HAROLD RUTLEDGE; RALPH ALLEN; THOMAS VADAS; VINCENT WORTH; TIMOTHY HILL, RONALD RAMSEY; JOHN IRELAND; JAMES MARTIN

v.

FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; THE MEDICAL CENTER OF OCEAN COUNTY; RIVERVIEW MEDICAL CENTER; COMMUNITY MEDICAL CENTER; JERSEY SHORE MEDICAL CENTER; KIMBALL MEDICAL CENTER; MONMOUTH MEDICAL CENTER NEW JERSEY HOSPITAL ASSOCIATION

Intervenor/Defendant

(Newark New Jersey District Civil No. 91-03897)

OVERLOOK HOSPITAL

v.

FRANCES DUBEAU; LILLIAN DUBEAU

(Newark New Jersey District Civil No. 91-03910)

LABORERS INTERNATIONAL UNION OF NORTH AMERICA LOCAL 415 HEALTH AND WELFARE FUND

v.

FRANCES J. DUNSTON. in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION

(Newark New Jersey District Civil No. 91-04078)

NYSA-ILA WELFARE FUND, by its Trustees; JOHN BOWERS, Trustee; ALBERT CERNADAS, Trustee; FRANK LONARDO, Trustee; THOMAS POPOLA, Trustee; JAMES CAPO, Trustee;

JOSEPH N. BARBERA, Trustee; BART DIMATTINA, Trustee; RICHARD H. O'NEILL, Trustee

v.

FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; COLUMBUS HOSPITAL; EAST ORANGE GENERAL HOSPITAL ST. JAMES HOSPITAL; UNIVERSITY HOSPITAL, Individually and as Class Representatives of Hospitals in the State of New Jersey; NEW JERSEY HOSPITAL ASSOCIATION,
as Class representative of Hospital in the State of New Jersey

(Newark New Jersey District Civil No. 91-04259)

SHEET METAL WORKERS LOCAL UNION NO. 25 WELFARE FUND; JEFFREY STAJEK; JAMES LUCIANO; JOHN A. FREUDENREICH, SR.; THOMAS SMIECH; JOSEPH MCCALLION; DANIEL SMITH, JR.; JAMES MCKAY; MARK COX

v.

FRANCES J. DUNSTON, in her capacity of New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; ADMINISTRATOR OF THE NEW JERSEY HEALTH CARE TRUST FUND; NEW JERSEY DEPARTMENT OF HUMAN SERVICES (DIVISION) OF MEDICAL ASSISTANCE AND HEALTH SERVICES; NEW JERSEY HOSPITAL ASSOCIATION; ST. BARNABAS MEDICAL CENTER; HOLY NAME HOSPITAL; HACKENSACK MEDICAL CENTER; WEST HUDSON HOSPITAL; OVERLOOK HOSPITAL; JOHN F. KENNEDY MEDICAL CENTER; HUNTERDON MEDICAL CENTER; MORRISTOWN MEMORIAL HOSPITAL; IRVINGTON GENERAL HOSPITAL; CLARA MAASS MEDICAL CENTER

(Newark New Jersey District Civil No. 91-04700)

TRUSTEES OF THE OPERATING ENGINEERS LOCAL 825 WELFARE FUND; RICHARD HORNECKER

v.

FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT

OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; ADMINISTRATOR OF THE NEW JERSEY HEALTH CARE TRUST FUND, NEW JERSEY DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

(Newark New Jersey District Civil No. 91-05362)

TEAMSTERS LOCAL 11 BENEFIT FUND; TRUSTEES OF THE TEAMSTERS LOCAL 11 BENEFIT PLAN; KATLUSKA BAIDAL; WILLIAM BARTELL; GUNTER BLOHM; ANGELO BUINNO; BETTY J. CAIRNS; FRANK CLOSE; JOSE CRUZ; SANTOS GARCIA; KAREN GENSURE; DOROTHY LARSON; RICHARD LITCHFIELD; SANDRA MARINO; JOHN MATUSZKIEWICZ; GEORGE MCCLAUGHLIN; OLGA MONTES; FERNANDO PEREZ; SANTO RAMOS; MARTHA SARA; ROXEEN SCALA; EDMUND SCOTT; CHARLIE TAYLOR; MELISSA TURI; SANGPO TSULDIN; COSMO VISENTINI

v.

BAYSHORE COMMUNITY HOSPITAL; CHILTON MEMORIAL HOSPITAL; CLARA MAASS MEDICAL CENTER; DOVER GENERAL HOSPITAL; ELIZABETH GENERAL MEDICAL CENTER; ENGLEWOOD HOSPITAL; HOLY NAME HOSPITAL; IRVINGTON GENERAL HOSPITAL; JERSEY CITY MEDICAL CENTER; PASSAIC GENERAL HOSPITAL; ST. FRANCIS HOSPITAL; ST. PETER'S MEDICAL CENTER; SOMERSET MEDICAL CENTER; UNION HOSPITAL; UNITED HOSPITAL; UNIVERSITY HOSPITAL; VALLEY HOSPITAL; WARREN HOSPITAL; FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION

(Newark New Jersey District Civil No. 92-00085)

TRUSTEES OF THE WELFARE TRUST FUND, LOCAL UNION NO. 475; WILLIE A. BARNES; HERMAN GEIGER; VINSTON LEE KING; KEVIN E. KLINE; ROBERT L. ROSA; WILLIAM BRENNAN; JAMES MURPHY, JR.; PATRICIA MCELLIGOTT; KEVIN MCCORMICK; PATRICK RYAN, JR.;

ANTHONY E. SMITH; ROBERT LAVERATT; JOHN S. WITTEK; JOHN MCQUILKEN; JOHN MONTESANO; ROY E. FRANK; JOHN O'NEILL, JR.; FRANK ROBINSON; DALE SCHAEFER; JOHN J. SERRA; DONALD SHERIDAN; WENCESLAO SOTO; MICHAEL J. RUSSO; JOSEPH P. MURPHY, JR.; CALVIN R. SUTTON, III; RONALD J. ZAKARZEWSKI; FRANK WHITNEY, SR.; JACK NACHTIGALL; LAWRENCE PARKIN; EDISON RODRIGUEZ; WILLIAM MORAN; VINCENT DOFFONT

v.

FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; ADMINISTRATOR OF THE NEW JERSEY HEALTH CARE TRUST FUND; NEW JERSEY DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES; WEST HUDSON HOSPITAL; UNIVERSITY OF MEDICINE & DENTISTRY; OVERLOOK HOSPITAL; MORRISTOWN MEMORIAL HOSPITAL; UNION HOSPITAL; RIVERVIEW MEDICAL CENTER; NORTHERN OCEAN HOSPITAL SYSTEM; COMMUNITY MEDICAL CENTER; HOSPITAL CENTER AT ORANGE; HUNTERDON MEDICAL CENTER; WARREN HOSPITAL; CENTRASTATE MEDICAL CENTER; SOMERSET MEDICAL CENTER; ROBERT WOOD JOHNSON UNIVERSITY; THE MEDICAL CENTER OF OCEAN COUNTY; JERSEY SHORE MEDICAL CENTER; COLUMBUS HOSPITAL; JOHN F. KENNEDY MEDICAL CENTER; CLARA MAASS MEDICAL CENTER

(Newark New Jersey District Civil No. 92-00426)

TEAMSTERS LOCAL 641 WELFARE FUND; CARLOS ROCHA; GEORGE KOESTER; CARMELA FERENS; KHOONRAJIE RAGHUBANS; PHILLIP SAVITTIERI; EARL PATTERSON; ROBERT REEDER

v.

FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; MEDICAL CENTER OF OCEAN COUNTY; ST. BARNABAS MEDICAL CENTER; CLARA MAASS

MEDICAL CENTER; ST. ELIZABETH HOSPITAL; PASSAIC GENERAL HOSPITAL

(Newark New Jersey District Civil No. 92-00526)

LOCAL 1245 HEALTH FUND; LOCAL 1245 BAKERY AND SPECIALTY HEALTH FUND; JAMES ARBOLINO; ANTHONY ROCCO; HAROLD POLSKY; NEVIO MANCIINI; WILLIE SCONIERS; IRENE HICKEY; KATHLEEN RODRIGUEZ; WILLIAM CLACKWORTHY; EDWARD NELSON; PATRICIA CONRAD; RONALD COZZO; HOLLY ANN CULBERT; JOACHIM SCHAFFRANIETZ; HUBERT CHASE; ROBERT BAUMAN; RUSSELL SCHWARTZ; JEAN JACQUES KERVAN; ARTHUR BEYER

v.

FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; DOVER GENERAL HOSPITAL; THE MEDICAL CENTER OF OCEAN COUNTY; SAINT BARNABAS MEDICAL CENTER; UNION HOSPITAL; JOHN F. KENNEDY MEDICAL CENTER; ENGLEWOOD HOSPITAL; MORRISTOWN MEMORIAL HOSPITAL; CENTRASTATE; SAINT PETER'S MEDICAL CENTER; SAINT MARY'S HOSPITAL; MEADOWLANDS HOSPITAL AND MEDICAL CENTER; JERSEY SHORE MEDICAL CENTER; KENNEDY MEMORIAL HOSPITAL; PASSAIC GENERAL HOSPITAL

(Newark New Jersey District Civil No. 92-00728)

ANTHONY RIZZO; JOSEPH ABBATE; JOSEPH MASSOUD; RALPH MASTRANGELO, as Trustees of the Local 945, I.B.T. Welfare Fund

v.

BARNERT MEMORIAL HOSPITAL CENTER; BAYONNE HOSPITAL; BAYSHORE COMMUNITY HOSPITAL; BERGEN PINES COUNTY HOSPITAL; CENTRASTATE MEDICAL CENTER; CHILTON MEMORIAL HOSPITAL; CHRIST HOSPITAL; CLARA MAASS MEDICAL CENTER; COLUMBUS HOSPITAL; COMMUNITY MEMORIAL HOSPITAL; DOVER GENERAL HOSPITAL & MEDICAL

CENTER; ELIZABETH GENERAL MEDICAL CENTER; GREENVILLE HOSPITAL; HACKETTSTOWN COMMUNITY HOSPITAL, HOLY NAME HOSPITAL; IRVINGTON GENERAL HOSPITAL; JERSEY SHORE MEDICAL CENTER; JOHN F. KENNEDY MEDICAL CENTER; KENNEDY MEMORIAL HOSPITALS AT SADDLE BROOK; KIMBALL MEDICAL CENTER; MERCER MEDICAL CENTER; MONTCLAIR COMMUNITY (HOSPITAL); MORRISTOWN MEMORIAL HOSPITAL; NEWTON MEMORIAL HOSPITAL; OVERLOOK HOSPITAL; PALISADES GENERAL HOSPITAL, PASCACK VALLEY HOSPITAL; PASSAIC BETH ISRAEL HOSPITAL; RAHWAY HOSPITAL; RARITAN BAY MEDICAL CENTER/PERTH AMBOY DIVISION; RIVERVIEW MEDICAL CENTER; ROBERT WOOD JOHNSON UNIVERSITY HOSPITAL; SOUTHERN OCEAN COUNTY HOSPITAL; ST. MARY'S HOSPITAL (PASSAIC); ST. JOSEPH'S HOSPITAL & MEDICAL CENTER; ST. FRANCIS MEDICAL CENTER; ST. ELIZABETH HOSPITAL; ST. PETER'S MEDICAL CENTER; THE GENERAL HOSPITAL CENTER AT PASSAIC; UNION HOSPITAL; UNIVERSITY HOSPITAL; UNIVERSITY OF MEDICINE & DENTISTRY OF NEW JERSEY; VALLEY HOSPITAL; WALLKILL VALLEY HOSPITAL AND HEALTH CENTERS; WARREN HOSPITAL; WAYNE GENERAL HOSPITAL; FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION

(Newark New Jersey District Civil No. 92-00849)

NEWCOMB MEDICAL CENTER

v.

JENNIS CARPENTER; ALICE CARPENTER, his wife, jointly, severally and in the alternative

Defendants/Third Party Plaintiffs

v.

FRANCES J. DUNSTON; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; ADMINISTRATOR OF THE NEW JERSEY HEALTH CARE TRUST FUND; NEW JERSEY DEPARTMENT OF HUMAN SERVICES, DIVISION OF

MEDICAL ASSISTANCE AND HEALTH SERVICES
Third Party Defendants

(Newark New Jersey District Civil No. 92-01282)

NEWCOMB MEDICAL CENTER

v.

SHANA TRIPP; CHARLES TRIPP, jointly, severally and in the alternative

Defendants/Third Party
Plaintiffs

v.

NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; ADMINISTRATOR OF THE NEW JERSEY HEALTH CARE TRUST FUND; NEW JERSEY DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES; FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health

Third Party Defendants

(Newark New Jerseys District Civil No. 92-01454)

NEWCOMB MEDICAL CENTER

v.

FRED KUEKEN
Defendant/Third Party
Plaintiff

v.

FRANCES J. DUNSTON; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; ADMINISTRATOR OF THE NEW JERSEY HEALTH CARE TRUST FUND; NEW JERSEY DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
Third Party Defendants

(Newark New Jersey District Civil No. 92-01455)

New Jersey Hospital Association; Bayshore Community Hospital; Monmouth Medical Center; Pascack Valley Hospital; Riverview Medical Center; Kennedy Memorial Hospitals at Saddle Brook, Inc.; William B. Kessler Memorial Hospital; St. Francis Hospital;

South Jersey Hospital System; Helene Fuld Medical Center; Newton Memorial Hospital; The Medical Center of Ocean County; Bayonne Hospital; Kennedy Memorial Hospitals-University Medical Center; South Amboy Memorial Hospital; Underwood Memorial Hospital; Muhlenberg Regional Medical Center; Englewood Hospital; Zurbrugg Memorial Hospital; St. Mary Hospital; Community Medical Center; Hunterdon Medical Center; St. Michael's Medical Center; The Mercer Medical Center; St. Peter's Medical Center; Jersey Shore Medical Center; Irvington General Hospital; John F. Kennedy Hospital; Our Lady of Lourdes Medical Center; Overlook Hospital; Raritan Bay Medical Center; St. Elizabeth Hospital; Wayne General Hospital; Barnert Hospital; Atlantic City Medical Center; Dover General Hospital & Medical Center; Holy Name Hospital; The Hospital at Orange; St. Clare's/Riverside Medical Center; Clara Maas Medical Center; Deborah Heart & Lung Center; Rahway Hospital; West Jersey Health System; Hackensack Medical Center; Newark Beth-Israel Medical Center; St. James Hospital; St. Joseph's Hospital & Medical Center; Christ Hospital; Chilton Memorial Hospital; East Orange General Hospital; Columbus Hospital; Cooper Hospital/University Medical Center; Memorial Hospital of Burlington County Memorial Health Alliance; Medical Center at Princeton; St. Joseph's Hospital; Shore Memorial Hospital; Robert Wood Johnson University Hospital; Burdette Tomlin Memorial Hospital; Somerset Medical Center; Mountainside Hospital; Union Hospital; United Hospitals Medical Center at Passaic; and Morristown Memorial Hospital,

Appellants

On Appeal From the United States District Court For the District of New Jersey

(D.C. Civil Action Nos. 90-02639, 90-03640, 91-00073, 91-00336, 91-02190, 91-03280, 91-03286, 91-03897, 91-03910, 91-04078, 91-04259, 91-04700, 91-05362, 92-00085, 92-00426, 92-00526, 92-00728, 92-00849, 92-01282, 92-01454, 92-01455)

Present: STAPLETON, SCIRICA, and NYGAARD,
Circuit Judges

J U D G M E N T

This cause came to be heard on the record from the United States District Court for the District of New Jersey and was argued by counsel September 18, 1992.

On consideration whereof, it is now here ordered and adjudged by this Court that the judgment of the said District Court entered May 28, 1992 and amended by order entered June 5, 1992, be, and the same is hereby reversed. The injunction is vacated and the cause is remanded to the District Court with instructions that judgment be entered for the defendants. All of the above in accordance with the opinion of this Court.

ATTEST:

Acting Chief Deputy Clerk

Dated: May 14, 1993

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

Nos. 92-5317/5319/5320/5341/5343/5345/5352/5354/5355

UNITED WIRE, METAL AND MACHINE HEALTH AND WELFARE FUND, ET AL.
V.
MORRISTOWN MEMORIAL HOSPITAL, ET AL.

SUR PETITION FOR REHEARING

BEFORE: SLOVITER, *Chief Judge*, BECKER, STAPLETON, MANSMANN, GREENBERG, SCIRICA, COWEN, NYGAARD, ALITO, ROTH, and LEWIS,
Circuit Judges

The petition for rehearing filed by appellees The trustees of the teamsters Local 11 Benefit Plan, Katulska Baidal, et al., New Jersey Carpenters Welfare Fund, District Council of Iron Workers of Northern New Jersey Welfare Fund, Local Union 400, IBEW Welfare Fund, Teamsters Local 641 Welfare Fund, Local 1245 Health Fund, Local 1245 Bakery & Specialty Health Fund, Trustees of the Welfare Trust Fund Local Union 475, et al., Teamsters Local 11 Benefit Plan, United Wire, Metal and Machine Health and Welfare Fund, Operating Engineers Local 825 Welfare Fund, NYSA-ILA Welfare Fund and Its Trustees, Local 807 and Trustees of Local 807, United Food & Commercial Workers International Union Local 464A, AFL-CIO Group Reimbursement Welfare Plan, Frank Lacatena and Dolores Lacatena, Sheet Metal Workers Local Union No. 25 Welfare Fund, Jeffrey Stajek, et al., Laborers International Union of North America Local 415 Health & Welfare Fund and the Hotel Employees and Restaurant Employees Welfare Fund, et al., in the above-entitled case having been submitted to the judges who participated in the decision of this Court and to all the other available circuit judges of the circuit in regular active service, and no judge who concurred in the decision having asked for rehearing, and a majority of the circuit judges of the circuit in regular active

service not having voted for rehearing by the court in banc, the petition for rehearing is denied. Judge Nygaard would have granted the petition for rehearing.

By the Court,
/s/

Circuit Judge

Dated: JUNE 15, 1993

United States District Court

FOR THE DISTRICT OF NEW JERSEY

UNITED WIRE, METAL & MACHINE HEALTH AND WELFARE FUND, et al.,

Plaintiffs,

v.

MORRISTOWN MEMORIAL HOSPITAL, et al.,

Defendants.

Civil Action No. 90-2639 (Consolidated)

OPINION

APPEARANCES:

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WOLIN, District Judge

Currently before the Court are defendants' and plaintiffs' cross-motions for summary judgment. Initially, this Court finds that the Eleventh Amendment does not prevent this Court from deciding any claims brought against the state agencies and the officials employed by the State of New Jersey. Likewise, this Court finds that New Jersey's hospital rate setting mechanism does not constitute a tax, and therefore the Tax Injunctive Act does not foreclose this Court from deciding the issues before it.

This Court will grant defendants' motions for summary judgment as to plaintiffs' federal constitutional claims. This Court further holds, however, that ERISA pre-empts certain provisions included in New Jersey's scheme for regulating hospital rates and the regulations promulgated thereunder. Therefore, this Court finds that New Jersey's hospital rate setting scheme is unenforceable. Due to the potential impact of its decision, this Court will stay its Order for a period of ten days to afford the parties an opportunity to appeal the Court's ruling to the Third Circuit Court of Appeals.

I. INTRODUCTION

Several self-insured union employee welfare benefit plans (the "Benefit Plans") qualified under the Employee Retirement Security Act 29 U.S.C. § 1002 *et seq.*, as amended ("ERISA") and their participants (the "individual plaintiffs") (collectively the "plaintiffs"), have brought an action in which they seek a declaration that contained New Jersey's scheme for setting hospital rates is invalid.[1] Plaintiffs argue that this Court must strike down the method New Jersey utilizes for determining hospital rates on both federal and state constitutional grounds and because ERISA pre-empts the state statute.

The gravamen of the complaint focuses on charges included within the hospital billing procedure which are in excess of a patient's "actual hospital costs." These include: costs of care for the indigent, charges to pay a hospital's bad debts, subsidies for the medicare program, and fees to reimburse hospitals for discounts given by the hospitals to other types of benefit plans.

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[1] This action was consolidated pursuant to order on January 31, 1992.

This Court has jurisdiction over plaintiffs' claims brought under the United States Constitution, ERISA and the Taft-Hartley Act pursuant to 28 U.S.C. § 1132. This Court has jurisdiction over plaintiffs' causes of action that arise under New Jersey's Constitution under the principles of pendent jurisdiction and supplemental jurisdiction, 28 U.S.C. § 1367.

In the exercise of its discretion, however, this Court declines to consider the Carpenter's Union's claim that this Court should force the Hospital Defendants to reimburse the charges paid by the Carpenter's Union under protest. The Court declines to exercise its pendent jurisdiction and supplemental jurisdiction over this state law claim in the interest of comity. The Carpenter's Union argues that the fees should be reimbursed because they were paid under compulsion — the hospital rate setting regulation forces a hospital to institute collection actions against parties who refuse to pay DRG rates. The New Jersey State Court's have never faced this issue. Moreover, the Hospital Defendants commenced related actions, which are currently pending in New Jersey, in which they seek reimbursement from plaintiffs who failed to pay the contested charges. In view of the interrelatedness of these actions, this Court will defer to the New Jersey State Courts.[2] Venue is proper in this district under 28 U.S.C. § 1391.

II. BACKGROUND

In 1971 New Jersey enacted the Health Care Facilities Planning Act (the "Act"), a hospital rate setting scheme for Blue Cross and certain federally funded programs such as Medicaid. L. 1971 c. 136 § 18. Rates were based primarily on a hospital's actual costs for each patient who participated in the programs encompassed by the law. In 1978, New Jersey passed a statute that amended the 1971 legislation and, in part, mandated rate setting for all payors. L. 1978 c. 83 ("Chapter 83"). Chapter 83 contained a dual purpose:

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[2] In their brief in opposition to the hospital defendants motion for summary judgment, plaintiffs concede that they are not asking this Court to apply its decision retroactively, but merely seek restitution because they paid the DRG rate under protest and duress. Accordingly, the issue of when to apply a decision retroactively under federal law does not confront this court. Thus, this Court can refuse to exercise its pendent jurisdiction over plaintiffs restitution claims.

to "contain the rising costs of health care services, and to ensure the financial solvency of hospitals."

Chapter 83 designed an interconnected regulatory system to embrace its purposes. Chapter 83 gave the Commissioner of Health (the "Commissioner") responsibility for overall supervision and administration of the hospital rates. The Commissioner, in conjunction with the Health Care Administration Board (the "Board"), proposes the rate schedule and determines, in accordance with the statute, the types of charges that should be included in hospital rates. Additionally, the law created the New Jersey Hospital Rate Setting Commission (the "Commission"). The Commission approves hospital rates. N.J.S.A. 26:2H-4.1; 26:2H-18.1; 26:2H-18.9; N.J.A.C. 8:31B-3.72; N.J.A.C. 8:31B-3.39. The New Jersey Department of Health (the "DOH") oversees the Commission and administers the rates.

In order to help contain costs, Chapter 83 set hospital rates prospectively, instead of upon actual cost. Under Chapter 83, various procedures are divided into diagnostic related groups ("DRG"), and a rate is assigned to each DRG. Instead of charging actual costs incurred by a hospital for treating an individual patient, the hospital has to charge the DRG rate which is designated for that classification. Despite the calculation of bills without regard to actual costs, a hospital bill still reflects a charge that previously represented actual costs. This charge is categorized as "total costs." A "DRG" charge also appears on a patient's bill.

A particular hospital's DRG rate consists of a weighted average of the cost incurred by that specific hospital to treat a particular illness and the average cost incurred by hospitals throughout the state to treat the condition. Accordingly, this system penalizes a hospital that incurs costs greater than that allocated to a particular DRG category and rewards hospitals that provide more efficient services for a particular DRG.[3]

Additionally, as part of its DRG rate, a hospital must include a charge for uncompensated care. Uncompensated care consists of

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[3] The costs incurred by a hospital include both direct costs and indirect costs. Direct costs include salaries and fringe benefits provided to employees engaged in the direct delivery of patient care, N.J.A.C. 8:31B-3.21, N.J.A.C. 8.31B-3.16. Indirect costs consists of funds expended by a hospital in order to manage the hospital, to allow the hospital to engage in research and to provide for the maintenance needed to upkeep a hospital.

both care to the indigent and expenses that result from bad debts. N.J.S.A. 26-2H 18.d; N.J.A.C. 8:31B-3.41; 8:31B-7.1. This charge stems from a hospital's mandate to admit anyone regardless of his or her ability to pay.[4] Only hospital patients incur costs for uncompensated care. In order to receive funds for uncompensated care a hospital must determine whether a patient has any health insurance.

Furthermore, hospitals that treat patients who have Medicare can recoup only the amount allotted by the Medicare system for the particular treatment. Medicare invariably pays less than the DRG rate allocated for a particular condition. N.J.S.A. 26H-18.1c, however, permits the Commissioner with the approval of the Board, "to adjust the DRG rate to account for costs incurred by statutes and regulations that affect the delivery of health care." Pursuant to this statute, the Commissioner, with the Board's approval, enacted N.J.A.C. 8:31B:3.73. This regulation allows the hospitals to include in their DRG rate an amount necessary to recover the difference between the Medicare rate of payment and the DRG rate. These costs are borne by non-medicare patients.

Moreover, Chapter 83 allows the Commission to decrease hospital costs for certain classes of payors. In particular, the Commission may grant a "payor differential" if it is supported by a "quantifiable economic benefit such as the degree of promptness and volume of payment to the hospital." N.J.S.A. 26:2H-18b. Pursuant to this provision, the Commission has granted a 2.2% discount to plans such as Blue Cross. None of the Benefit Plans currently receive such a discount. Only the Carpenter's Union Trust Fund (the "Carpenter's Union"), has requested such a discount. The Commission has not yet reached a decision as to the Carpenter's Union's application.

In addition to the 2.2% discount the Commission grants an 11% discount to plans with open enrollment. Because the Benefit Funds

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[4] The 1978 Amendments mandated an inclusion in the DRG rate for uncompensated care costs. The uncompensated care costs attributed to a particular hospital was borne only by that hospital's patients. In 1987 New Jersey again amended the hospital rate setting system. Under the Amendments, hospitals throughout the state shared equally in the cost of uncompensated care. Thus, the hospital bill of each patient is increased by the same amount in order to compensate hospitals for uncompensated care costs. Currently, a hospital increases a patient's bill 19% for uncompensated care. The New Jersey Health Care Trust Fund then distributes the money collected for uncompensated care to each hospital according to that particular hospital's needs.

must limit their enrollment to union members and their families, the Benefit Funds cannot receive this discount. The bills of patients who did not belong to plans that received these discounts were increased in order to supply hospitals with the reduced income they lost because of the discounts. N.J.A.C. 8:31B-3.39.

Regulations, promulgated in accordance with the rate setting scheme, contain an appeal process for individuals whose DRG costs exceed their total costs by $250.00. Individuals who have third party insurance that does not reimburse the hospital according to DRG rates or that contains a deductible are not eligible to appeal. Accordingly, none of the individual plaintiffs can avail themselves of the appeal process.

The Benefit Plans do not provide the same type of payments for hospital costs incurred by their members. For example, the District Council of Ironworkers of Northern New Jersey Welfare Fund (the "IWF") Benefit Plan covers 95% of the actual hospital costs incurred by its members.[5] The NYSA-ILA Welfare Plan, however, compensates the hospital for about 75% of the total fees charged to its participants. Still, other Benefit Plans pay 100% of the DRG charges.

Plaintiffs instituted their Second Amended Complaint against certain New Jersey entities and administrators employed by New Jersey who are associated with the rate setting provisions (the "State Defendants").[6] Plaintiffs also sued various hospitals (the "Hospital Defendants") (with the State Defendants collectively the "defendants"). The Hospital Defendants must charge DRG rates in order to maintain the licenses that permit the hospitals to provide health care.

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[5] Prior to April 16, 1991, the IWF paid 95% of the DRG rate imposed by the hospitals. Concurrent with its decision to reimburse only 95% of actual hospital cost, the IWF instructed its members to submit only the 5% difference in total costs to the hospitals. Mandated by the Act the hospitals have begun collection procedures in state court to recoup the unpaid DRG charges. Following its decision to reimburse only 95% of total costs the IWF placed the difference between 95% of the DRG rate and 95% of total costs into an escrow account.

[6] Specifically, plaintiffs named the DOH, the Commission, the Administrator of the New Jersey Health Care Trust Fund, the Department of Human Services Division of Medical Assistance and Health Services and the Commissioner of Health as defendants.

In their complaint, plaintiffs allege that this Court must strike down New Jersey's hospital rate setting scheme for the following reasons: (1) the scheme is pre-empted by § 501(a) of ERISA, 29 U.S.C. § 1132(a), and by § 186(c) of the Taft Hartley Act, 29 U.S.C. § 186(c)[7]; (2) it deprives plaintiffs of the due process and equal protection rights guaranteed to them under the Constitutions of the United States and the State of New Jersey; (3) it constitutes a taking of property without just compensation under the United States Constitution; (4) it imposes a special tax law in violation of the New Jersey Constitution; and (5) it improperly delegates taxing power to the Commissioner because it gives the Commissioner "unchecked power" to establish hospital rates.

In addition to contesting each of the allegations asserted by plaintiffs, the defendants contend that this Court has no authority to hear this case. First, the State Defendants assert that the Eleventh Amendment protects them from the instant lawsuit. Second, the defendants allege that if the hospital rates constitute a tax, the Tax Injunctive Act prohibits this Court from hearing the instant motion.

III. DISCUSSION

A. State Immunity Under the Eleventh Amendment

The State Defendants allege that they have not consented to suit and therefore, the Eleventh Amendment forecloses any action against them. The Eleventh Amendment does not prohibit suits for prospective injunctive relief and declaratory relief against state agencies and state officials where plaintiffs contend that actions taken by these agencies and officials, in their official capacity, have violated the federal constitution or federal statutes. *Geis v. Board of Education of Parsippany-Troy Hills*, 744 F.2d 575, 580 (1985). This exception to immunity applies even if issuing the declaratory or injunctive relief would reduce state funds. *Edelman v. Jordan*, 415 U.S. 651-52, 94 S. Ct. 1347 1358-59 (1974). Similarly, suits that seek injunctive relief and assert that the state exceeded powers granted to it by its own constitution are not prohibited by the Eleventh Amendment. *Capitol Industries-Emi, Inc. v. Bennett*, 681 F.2d

[7] Plaintiffs have offered no support for their preemption claim brought under the Taft-Hartley Act. Moreover, plaintiffs concede that preemption under § 186(c) applies more narrowly than under § 501(a) of ERISA. Therefore, this Court rejects plaintiffs preemption claim under the Taft-Hartley Act.

1107, 1120 (9th Cir.), *cert. denied*, 459 U.S. 1087, 103 S. Ct. 570 (1982).

Because plaintiffs seek solely prospective injunctive and declaratory relief, the Eleventh Amendment does not bar their action commenced against any State Defendant. Moreover, even if this Court's ruling decreases funds available to the state with which they can help defray the costs of medical expenses of its citizens, this still does not foreclose this action against the State Defendants. Likewise, the Eleventh Amendment does not preclude plaintiffs' claim that the Legislature unconstitutionally delegated the taxing power to the Commission.

B. Application of the Tax Injunction Act (the "TIA")

Before this Court can consider the merits of the motions before it, the Court must decide whether the TIA bars any of plaintiffs claims. The TIA provides:

> The district court shall not enjoin, suspend or restrain the assessment, levy or collection of any tax under State law where a plain, speedy and efficient remedy may be had in the courts of such State.

28 U.S.C. § 1341. Accordingly, in order to determine whether an action falls under the TIA the Court conducts a two-step analysis. First, the Court must determine if the charge at issue constitutes a tax. If the expense is a tax, then the Court must decide whether the State provides a "plain speedy and efficient remedy." 28 U.S.C § 1341[8]

At the outset, this Court notes that the TIA clearly applies to the types of claims and relief that plaintiffs seek. First, it is well settled that actions for declaratory relief as well as for injunctive relief are barred by the TIA. *See Franchise Tax Board v. Alcoa Aluminum, Ltd.*, 493 U.S. 331, 110 S. Ct. 661 (1990). Additionally, the TIA encompasses federal constitutional challenges to the imposition of a state tax. *See Hardwick v. Cuomo*, 891 F.2d 1097, 1100 (3d Cir. 1989) (plaintiffs' equal protection challenge to imposition of non-resident tax barred by TIA).

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[8] The Third Circuit has held that the TIA is a jurisdictional statute. *Sipe v. Amerada Hess Corp.*, 689 F.2d 396 (3d Cir. 1982). Hence, the Court cannot hear any matters that fall within the scope of the TIA.

Congress enacted the TIA in order to "prevent federal court interference with the assessment and collection of state taxes" by parties who brought suits in federal court to enjoin a state or local government's collection of taxes. *Hardwick*, 891 F.2d at 1105. Congress recognized that states had a "pressing need" to collect revenues. As a result, state and local governments "would compromise [a party's claim] by taking less than the tax due." *Tramel v. Schrader*, 505 F.2d 1310, 1315 (5th Cir. 1975).

The difficult question faced by this Court is whether any of the costs included in the DRG rate constitute a tax. Initially, this Court finds that it must conduct its analysis under federal and not state law. *Robinson Protective Alarm Company v. Philadelphia*, 581 F.2d 371, 374 (3d Cir. 1978) ("'[T]ax under state law' in 28 U.S.C. § 1341 should be determined as a matter of federal law by reference to congressional policies underlying the Tax Injunction Act, rather than by adoption of state tax labels developed in entirely different legal contexts.").[9]

No bright-line exists between assessments which are "taxes under state law" and those which are not. Recently, the court in *Butler v. Maine Supreme Judicial Court*, 767 F. Supp. 17, 18 (D. Me. 1991), concisely stated the accepted definition of "taxes." In general, "assessments imposed primarily for revenue raising purposes are 'taxes,' while those levies assessed for regulatory or punitive purposes, even though they may also raise revenues, are generally not 'taxes.' " *Id.* (citations omitted).

The Third Circuit has followed this definition. For example, in *Robinson*, the Third Circuit held that an assessment of 5% of gross earnings levied upon alarm station companies who used underground wires constituted taxes. The Court examined the character of the assessments. It found that the taxes were "collected annually in a manner similar to other gross receipts levied." Moreover, it noted that the monies collected were "added to the public fisc rather than applied exclusively to contractual services owed central alarm station companies."[10] Thus, the court concluded that Philadelphia

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[9] Accordingly, plaintiffs' argument that the "add-ons" constitute a tax because the Commission on Hospital Rates termed them as such is of no moment to this Court.

[10] Plaintiffs argument that the DRG rates constitute taxes because matching funds collected from the federal government under the Medicare Program are placed in the public fisc is simply a red herring. This Court must only determine whether

taxed the plaintiffs under the TIA. *See also Butler*, 767 F. Supp. at 17 (D. Me. 1991) (state exacted tax from plaintiffs when it imposed $300 jury fee on plaintiffs in state court action. Fees collected were "funnelled into Maine's general fund [and not] applied directly to the costs of jury trials.").

The dictum announced by the Third Circuit supports the conclusion that if Philadelphia applied the revenue collected to the regulated industry, the court would have held that Philadelphia did not tax the alarm station companies. *Cf. Rural Telephone Coalition v. F.C.C.*, 838 F.2d 1307 (D.C. Cir. 1988) (FCC order to allocate 25% of traffic sensitive costs from local telephone companies to long distance telephone did not impose a tax. Primary purpose of the ruling was not to raise revenue but only to regulate rates.); *Brock v. Washington Metropolitan Area Transit Authority*, 796 F.2d 481 (D.C. Cir. 1986), *cert. denied, Washington Metropolitan Transit Authority v. Brock*, 481 U.S. 1013, 107 S. Ct. 1887 (1987) (statute that mandated employers to contribute to special fund from which several types of workers compensation payments were made did not impose taxes on employers. Statute's primary purpose was to "regulate liability for industrial accidents" and not to finance the government's general programs. Fund was segregated from other fees collected.) *Head Money Cases*, 112 U.S. 580 (1884) (Duty on immigrants collected from shipowners and segregated into its own fund which was imposed in order to defray the expense of regulating immigration and for the care of immigrants did not exact a tax from shipowners but instead only implicated the Commerce Clause).

Guided by the dictum in *Robinson*, this Court holds that the contested costs included in the DRG rate do not constitute a tax. The state never uses the money collected from plaintiffs for the general welfare. Additionally, the fees collected are never intermingled in a general fund. Instead, the fees defray the costs that hospital's incur pursuant to state regulation of hospital costs. Hence, this Court finds the TIA does not apply. Accordingly, this Court has jurisdiction over plaintiffs' claims.

(Continued)
the costs included within the DRG rate constitute a tax. Money obtained by New Jersey from the federal government that are related to some of the DRG costs has no bearing on this analysis.

Courts in various circuits have found that special assessments collected by the government to fund specific programs constitute a tax under the TIA. For example, in *Tramel*, the Fifth Circuit held that a special street improvement assessment levied on plaintiffs who owned land which abutted the streets that the City wanted to improve constituted a tax. 505 F.2d at 1312. The court reasoned that to hold otherwise would defeat the purposes of the TIA. In particular, the court held a contrary finding would permit parties to "delay or to frustrate the revenue collection process by resorting to federal courts." *Id.* at 1316.

Similarly, the Sixth Circuit held that a state law which required "parolees to make monthly payments to a supervision fund and to a victim's compensation fund," imposed a tax on parolees. *Wright v. McClain*, 835 F.2d 143 (6th Cir. 1987). The Sixth Circuit acknowledged that the funds collected were used only by the Corrections Department. *Id.* at 145. The Sixth Circuit reasoned, however, that the fees constituted revenue because they were used "[by the government] to defray the cost to the general public of monitoring and supervising the behavior of convicted offenders and to compensate, in some measure, victims of criminal misconduct." *Id.* Thus, the court concluded that even though the funds were earmarked for a particular use by the state they were taxes.

The decisions discussed above do not disturb the Court's holding. Unlike the cases cited above, the charges included in the DRG rate do not fund special programs financed by New Jersey. Instead, they allow hospitals regulated by New Jersey to meet their financial obligations. Therefore, the TIA is inapplicable to the action before this Court.[11]

C. ERISA Pre-emption

Plaintiffs argue that ERISA pre-empts the method New Jersey utilizes for establishing hospital rates. Initially, plaintiffs contend that ERISA pre-empts Chapter 83's method of setting hospital

[11] Because this Court finds that costs included in the DRG rates are not taxes, this Court will not determine whether the TIA applies to actions brought under ERISA.

rates, determining who is eligible to appeal DRG costs, and deciding who can receive a discounted rate, because these provisions "relate" to an employee benefit plan. Plaintiffs further allege that the charges included in the DRG rates for uncompensated care, Medicare, and appeals granted to individuals constitute taxes that are impermissible under an express provision of ERISA because they relate to an employee benefit plan.[12]

ERISA contains an explicit pre-emption provision. Section 514(a) of ERISA pre-empts state laws that "relate to any employee benefit plan." 29 U.S.C. § 1144(a) ("§ 514(a)"). The Supreme Court has consistently interpreted the pre-emption clause broadly. *See FMC v. Holliday Corp.*, 111 S. Ct. 403, 407 (1990) ("The pre-emption clause is conspicuous for its breadth. It establishes as an area of exclusive federal concern the subject of every state law that 'relates to' an employee benefit plan governed by ERISA."); *Franchise Tax Board*, 463 U.S. 1, 24, 103 S. Ct. 2841, 2854 n.26 ("ERISA's commodious pre-emption provision is virtually unique."). Accordingly the Supreme Court has refused to define "relate to" narrowly. Instead, the Supreme Court has announced:

> A law relates to an employee benefit plan in the normal sense of the phrase if it has a connection with or reference to such a plan.

Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 107 S. Ct. 1549, 1552 (1987).

Guided by the broad language contained in the preemption clause, the Supreme Court has held that ERISA pre-empts a state law even where a state law affects ERISA indirectly or the law was not "specifically designed to affect such plans." *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525, 101 S. Ct. 1895, 1907 (1981). Similarly, the Supreme Court has held that the preemption clause does not apply only to "state laws dealing with the subject matter covered by ERISA: reporting, disclosure, fiduciary responsibility and the like." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97-98, 103 S. Ct. 2890, 2900. Moreover, ERISA pre-empts a state law even if the law "[is] consistent with ERISA's substantive requirements." *Metropolitan Life Insurance Co. v. Massachusetts*,

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[12] Because this Court finds that ERISA pre-empts New Jersey's method of setting hospital rates, regardless of whether the charges challenged by plaintiffs constitute a tax, this Court will not decide the tax issue.

471 U.S. 724, 105 S. Ct. 2380, 2388-89 (1985) (citing) 103 S. Ct. at 2900-2901, or the law was enacted to "effectuate ERISA's underlying purposes." *Mackey v. Lanier Collection Agency & Service Inc.*, 486 U.S. 825, 108 S. Ct. 2182, 2185 (1988).

In *Ingersoll-Rand Co. v. McClendon*, ____U.S. ____, 111 S. Ct. 478, 484 (1990), the Supreme Court recently affirmed the broad reach of ERISA. In *Ingersoll*, the defendant contended that § 514(c)(2) of ERISA limited the scope of § 514(a). Section 514(c)(2) provides:

> The term State includes a State, any political subdivisions thereof, or any agency or instrumentality of either which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter. 29 U.S.C. § 1144(c)(2).

(Emphasis added). Based on ERISA's definition of "State," the defendant in *Ingersoll* concluded that § 514(a) only applies to state laws that "affect plan terms, conditions, or administration [of an ERISA plan]."

The Supreme Court, however, rejected this argument. First, the Supreme Court explained that Congress expanded the definition of state in order to enlarge the grasp of ERISA. Hence, defendant's restrictive reading of § 514(a) would defeat Congress's purposes. Second, the Supreme Court concluded that if Congress intended to restrict § 514(a) in the manner proposed by defendant it would have included the limiting language in § 514(a) itself. *Id.* Therefore, the Supreme Court refused to narrow the reach of the plain meaning of the language contained in § 514(a).

The Supreme Court's broad reading of ERISA's preemption clause stems not only from the plain meaning of the provision itself, but also from the legislative history of ERISA. Specifically, Congress rejected a pre-emption clause that only "appli[ed] to state laws [which] relat[ed] to the specific subjects covered by ERISA." *Shaw*, 103 S. Ct. at 2900; *FMC*, 111 S. Ct. at 408. Similarly, Congress excluded a state's "generally applicable criminal laws" from pre-emption. *Id.* Such an exclusion would have been unnecessary if Congress intended § 514(a) to apply only to "state laws dealing specifically with ERISA plans." 103 S. Ct. at 2900; 111 S. Ct. at 408.

Finally, the legislative history reveals that Congress enacted ERISA in order to give federal authorities "sole power to regulate the field of employee benefit plans." *Pilot Life Ins. Co.*, 107 S. Ct. at 1552 (quoting) 120 Cong. Rec. 29197 (1974). Accordingly, Congress enacted a broad pre-emption clause in order to "eliminate the threat of conflicting or inconsistent State and local regulation of employee benefit plans." *Id.* (quoting) 120 Cong. Rec. at 29933.

Following the dictates of Congress, the Supreme Court has held that ERISA superseded state laws that forced a benefit plan to structure benefits in a specific manner. Similarly, the Supreme Court has invalidated state laws that could subject an ERISA plan to inconsistent state regulations. As noted above, whether a state law mentioned ERISA plans was not a critical factor in the Supreme Court's decision.

For example, in *Alessi*, 451 U.S. at 508-09, 101 S. Ct. at 1898, New Jersey forbade reducing retirement benefits or payments by the amount of money a person received under worker's compensation. The Supreme Court held that ERISA pre-empted New Jersey's law. In particular, the Supreme Court found that New Jersey's law impermissibly "eliminate[d] one method for calculating pension benefits." As a result, New Jersey's regulation would force a pension plan either to change its manner for computing benefits for all plans both within and outside New Jersey or to require the plan to calculate benefits for New Jersey employees in a manner different from the manner used for employees outside New Jersey. Moreover, the Supreme Court reached its conclusion irrespective of the New Jersey law's beneficial purposes. Additionally, the Supreme Court held that it made no difference that "New Jersey intrudes indirectly through workers compensation rather than directly through a statute called pension regulation." Importantly, although the Supreme Court recognized that New Jersey's law constituted an exercise of its police powers, the Court still held that ERISA pre-empted the law.

Likewise, in *FMC*, 111 S. Ct. at 406, the Supreme Court held that ERISA pre-empted Pennsylvania's anti-subrogation law. Pennsylvania's law prohibited a party from subrogating his or her tort recovery "in an action arising out of the maintenance or use of a motor vehicle" to any plan that paid the party benefits related to the accident. *Id.* Contrary to Pennsylvania's law, the benefit plan at

issue in *FMC* provided that a participant would reimburse the plan with any recovery obtained from a third party.

In reaching its conclusion, the Supreme Court found that Pennsylvania's law restricted the way in which the plan could provide benefits. Additionally, the Court reasoned that Pennsylvania's statute would subject the plan to inconsistent regulations. This would "frustrate plan administrators continuing obligation [under ERISA] to calculate uniform benefit levels nationwide." Therefore, the Supreme Court held that Pennsylvania's anti-subrogation law was unenforceable.[13] *See also Shaw*, 463 U.S. 85, 103 S. Ct. 2890 (1983) (ERISA pre-empted New York law that mandated benefits for pregnancy. Law forced ERISA plans to structure benefits in a particular manner and subjected plans to inconsistent regulations).

Following the Supreme Court's interpretation of § 514(a), the Eighth Circuit held in a recent decision that ERISA pre-empted Arkansas' general assignment statute. The Arkansas statute made no reference to an ERISA plan. Instead, the statute provided:

> all bonds, bills, notes, agreements, and contracts, in writing, for the payment of money or property, or for both money and property, shall be assignable.

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[13] The Supreme Court also found that Pennsylvania's law related to ERISA because it referenced employee welfare plans. In particular, the statute encompassed "any program group contract or other arrangement for payment of benefits." It further defined the aforementioned terms as "including but not limited to, benefits payable by a hospital plan corporation or a professional health service corporation." (Emphasis added). Hence, the Supreme Court found that Pennsylvania's law referenced employee benefits plans even though the statute (1) never explicitly mentioned such plans and (2) simply failed to exclude them from a catchall provision.

Plaintiffs contend that ERISA pre-empts the DRG scheme because the policy that contains the appeal procedure and Chapter 83 itself reference employee benefit plans. In particular, the appeal policy "denies the right to appeal a hospital bill to any plan participant if the 'third-party payer (commercial insurance, self-funded union, etc) requests an appeal on the basis of excessive charges'; or if the 'third party payer (commercial insure, self-funded union, etc.) does not reimburse the hospital on the DRG price per case. Moreover, in order to receive funds for uncompensated care a hospital must ask a patient whether he or she is covered by insurance including "whether such coverage is from a 'union welfare plan'."

Defendant's argue that these provisions do not refer to employee benefit plans, but merely use them as examples. In light of the *FMC* Court's opinion, defendants' argument fails, and this Court holds that the explicit reference to ERISA plans contained in the Chapter 83 provides further support for ERISA preemption.

Ark. Code Ann. § 4-58-102. The benefit plan at issue forbade assignment of benefits unless the benefit plan approved the assignment. Accordingly, the plan conflicted with Arkansas' statute that provided for unconditional assignment of such benefits.

In reaching its conclusion, the court noted that the statute negated a provision of the benefit plan. More importantly, the Eighth Circuit found that the law would subject the plan to inconsistent regulations throughout the country. Equally significant was the Eighth Circuit's opinion that the statute affected relationships among primary ERISA entities. Primary ERISA entities are — the employer, the plan, the plan fiduciaries, and the beneficiaries. In particular, the Eighth Circuit reasoned that the "assignment statute takes from the claims administrator who is a plan fiduciary, and gives to the beneficiaries control over who should receive payment of ERISA plan welfare benefits."[14]

Although the Supreme Court has interpreted § 514(a) broadly, the Court has cautioned that "some state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to the plan.' " *Shaw*, 103 S. Ct. 2890 at 2901 n.21. Thus, ERISA would not pre-empt "a generally applicable statute that makes no reference to, or indeed functions irrespective of, the existence of an ERISA plan." *Ingersoll-Rand*, 111 S. Ct. at 483; *see also Aetna Life Ins. Co. v. Borges*, 869 F.2d 142 (2d Cir.), *cert. denied*, 493 U.S. 811 (1989).

In *Mackey*, the Supreme Court held that ERISA did not pre-empt Georgia's garnishment statute that applied to any Georgia citizen, even when applied to benefits of participants in plans covered by ERISA. The fact that the law caused administrative burdens to ERISA plans did not suffice to pre-empt Georgia's garnishment statute.

Similarly, in *Aetna* the court concluded that ERISA did not pre-empt Connecticut's abandoned property laws. Aetna Life Insurance Company provided health and accident insurance. Often, Aetna would approve a claim for benefits, but the beneficiary would fail to collect the benefits. *Id.* at 143-44. The court held that ERISA's pre-emption clause did not prevent Connecticut from recovering the

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[14] In its decision the Eighth Circuit equated an effect on primary ERISA entities with the Supreme Court's often mentioned effect on an ERISA benefit plan's structure.

uncollected benefits. Connecticut's escheat law applied to all types of abandoned property, and it was insignificant that the abandoned property in this particular case consisted of the benefits provided under a plan covered by ERISA. *Id.* at 147-48.

Significantly, the law did not obligate the plan to cover certain benefits nor did it interfere with the calculation of benefits, the economic impact on ERISA plans did not threaten the purpose of ERISA to subject the plans to "national uniform supervision." *Id. See also Benefax Corporation v. Wright*, 757 F. Supp. 800 (W.D. Ky. 1990) (Even if Georgia licensing statutes that applied to administrators related to ERISA plans, affect would be too remote or tenuous for ERISA to pre-empt the statute. The statute applied to any administrator regardless of whether he or she administered a plan qualified under ERISA and "[did] not affect the relationship between principal ERISA entities other than to determine who can or cannot serve as an administrator.").

Additionally, the Supreme Court has held that laws that relate solely to benefits and not to benefit plans are not preempted by § 514(a). Accordingly, in *Ft. Halifax Packing Co. Inc. v. Coyne,* 482 U.S. 1, 107 S. Ct. 2211 (1987), the Supreme Court refused to find that ERISA pre-empted a Maine statute. The statute required an employer to pay employees a one time severance payment in the event of a plant closing. The Court ruled that the statute referred to a benefit and not to a benefit plan.

In so doing, the Court noted that the severance payment did not "establish a benefit plan," nor did it force an employer to "maintain a benefit plan." Further, the Court explained that the one time severance payment did not subject any benefit plan to inconsistent regulations. Finally, the Court concluded that the one time payment did not create continuing administrative hardships on an employee benefit plan. Therefore, the Court determined that ERISA did not pre-empt Maine's statute.

Plaintiff's correctly argue that the contested provisions in Chapter 83 relate to ERISA and are therefore preempted by § 514(a). Chapter 83 both forces the benefit plans to structure benefits in a particular manner and subjects the benefit plans to inconsistent regulations. The fact that the these provisions do not mention benefit plans directly and do not regulate the terms and conditions of such plans explicitly, has no bearing on this Court's findings.

In particular, the charges included in the DRG rate for uncompensated care, the shortfall for Medicare, and the discounts granted to certain payors, force the Benefit Plans to incur costs for the benefit of others if the Benefit Plans provide benefits to cover total hospital costs. The Benefit Plans themselves are not allowed to disburse funds to anyone other than a plan participant. As a result, Benefit Plans that are mandated to pay total hospital costs must disregard their express purposes.

Furthermore, in states in which hospital rates do not include costs for others, the Benefit Plans can abide by their express purposes. Hence, the plans are subjected to inconsistent regulations. Accordingly, plan members in different states receive different and disproportionate benefit amounts depending whether a given state's hospital rate setting policy includes charges beyond "actual hospital costs." Consequently, this Court finds that these provisions and the regulation promulgated thereunder frustrate ERISA's purpose of subjecting benefit plans to uniform federal regulations.

Additionally, ERISA itself forbids benefit plans from paying benefits for anyone other than a plan beneficiary. This proscription further compels this Court to find ERISA pre-empts Chapter 83's contested provisions and the regulations promulgated thereunder.[15] *See McLaughlin v. Rowley*, 698 F. Supp. 1333, 1339 (N.D. Tex. 1988) (ERISA pre-empted Texas Usury statute that prevented plan trustees from charging more than 10% interest on loans in light of ERISA provision that compelled "plan fiduciaries to obtain market rates on plan investments."); *Arkansas Blue Cross & Blue Shield v. St. Mary's Hospital, Inc.*, 947 F.2d 1341, 1349 (8th Cir. 1991)

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[15] Defendants erroneously argue that Chapter 83 affects hospitals, not benefit plans. According to defendants, Chapter 83 forces hospitals to charge certain rates and does not foreclose the Benefit Plans from covering any portion of a participant's hospital bill. In light of the express purposes of both the Benefit Plans themselves and the dictates of ERISA, both of which prevent a Benefit Plan from covering costs of anyone except plan beneficiaries, this argument is at the least misleading. Moreover, defendants' argument simply ignores the Supreme Court's finding that ERISA pre-empts state laws that indirectly affect benefit plans.

Furthermore, defendants contend that Chapter 83 does not subject the Benefit Plans to inconsistent regulations because inconsistencies currently exist in the rates set by hospitals in various states. This argument is spurious. Plaintiffs are not advocating that hospitals in each state set identical rates. Instead, they argue that a state cannot include certain types of costs within its hospital rates. By including these type of costs, which other states might not include, New Jersey subjects Benefit Plans to inconsistent regulation.

(ERISA provision that prohibited assignment or alienation of ERISA plan benefits weighed in favor of pre-empting Arkansas law that unconditionally allowed assignment of any contract).

Moreover, because the purpose of the Benefit Plans and ERISA itself foreclose the plans from paying DRG rates, the participants in the plans lose any right to appeal the cost of their hospital bills. Again, only if the Benefit Plans choose to ignore the dictates of ERISA and pay DRG rates can the beneficiaries avail themselves of an appeal. This lack of parity with other hospital payors arises because of a Benefit Plan's administration and it is this relationship that undergirds the argument in support of pre-emption. Moreover, by virtue of their status, the Benefit Plans cannot qualify for an open enrollment discount. Importantly, the Benefit Plans must subsidize the recipients of these discounts. This further supports ERISA preemption.

Additionally, as opposed to the statutes at issue in both *Mackey*, and *Aetna Life Insurance*, the contested provisions in Chapter 83 are not simply tenuously connected to the Benefit Plans and which only affects the Benefit Plans by increasing their costs. Contrastingly, the disputed provisions affect the structure of the Benefit Plans themselves. Moreover, this Court finds that unlike the Supreme Court's decision in *Fort Halifax*, the offending provisions in Chapter 83 and the corresponding regulations do not simply constitute a benefit that forces the Benefit Plans to make a one time payment. Instead they subject the Benefit Plans to "ongoing administrative hardship." For these reasons, this Court finds that § 514(a) pre-empts ERISA.

Defendants argue, however, that ERISA does not pre-empt these provisions because they constitute a law of general application that has a too "tenuous, remote, or peripheral" effect on an employee benefit plan. Defendants rely primarily on *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), to support their contention. In *Rebaldo* the Second Circuit held that § 514(a) did not pre-empt a New York statute that exempted small insurance funds which excluded employee benefit plans under ERISA from negotiating discounts with hospitals. Insurers such as Blue Cross were allowed to negotiate with hospitals for the discounts at issue.

The Second Circuit held that New York's law was solely a law of general application that failed to "affect the structure, administration or type of benefits provided by an ERISA plan." According to the court, the "mere fact that statute ha[d] some economic impact on the plan d[id] not require that the statute be invalidated."

As opposed to the statute at issue, the contested provisions in Chapter 83 do not only have an economic effect on ERISA plans. Instead, these provisions force Benefit Plans to structure benefits in a particular manner and subjects Benefit Plans to inconsistent regulations. Therefore, under the standard announced by *Rebaldo*, this Court would find that ERISA pre-empts Chapter 83.

Moreover, in light of recent decisions, the underlying rationale stated by the *Rebaldo* court is at the very least subject to question. In particular, the *Rebaldo* court reasoned that a "state law must purport to regulate the terms and conditions of employee benefit plans to fall within the preemption provision." As discussed above, the Supreme Court in *Ingersoll* faced this precise reading of § 514(a) and rejected it.

The *Rebaldo* court concluded that "containment of hospital costs is an exercise of police powers which should not be superseded by federal regulations unless there was a clear intent of Congress." In *Gilbert v. Burlington Industries. Inc.*, 765 F.2d 320, 327 (2d Cir. 1985), *aff'd*, 47 U.S. 901, 106 S. Ct. 3267 (1986), the Second Circuit revisited the weight to be given in an analysis under § 514(a) to a state's exercise of its police powers and attributed less weight to this factor than allotted to it by the *Rebaldo* court.

Specifically, the court in *Gilbert* stated, "in addition to being an exercise of traditional police power [a state law] must also affect the plan in too tenuous remote or peripheral a manner to warrant a finding that the law relates to the plan." Importantly, the *Gilbert* court pre-empted a state law that constituted an exercise of the state's traditional police powers because it found that the state law did not have a "remote or tenuous connection" to ERISA.

In *Boise Cascade Corp. v. Peterson*, 939 F.2d 632, 638 (8th Cir. 1991), the court similarly held that the minimum ratio rule that regulated the ratio of pipe-fitters to apprentices working on Minnesota job-sites and which had been effect since 1947 was pre-empted by ERISA. The Court specifically found that the state passed the minimum ratio law as an exercise of its police powers. In particular, the

court noted that the state enacted the statute at issue in order to protect its citizens' safety. Because the law failed to affect the plan solely in a "tenuous, remote or peripheral manner," however, the court held ERISA pre-empted the statute. *See also Arkansas Blue Cross & Blue Shield*, 947 F.2d at 1351 ("[W]e do not believe that whether the assignment statute is an exercise of traditional state authority favors or disfavors a finding of pre-emption"). Given that subsequent decisions have attacked *Rebaldo's* reasoning, this Court accords *Rebaldo* limited weight.

Other court decisions subsequent to *Rebaldo* that involved hospital rate setting schemes have found that ERISA preempted the scheme at issue. For example, in *Bricklayers Local No. 1 Welfare Fund v. Louisiana Health Insurance*, 771 F. Supp. 771, (E.D. La. 1991), the court held that ERISA pre-empted the statute that created the Louisiana Health Insurance Association (the "Association"). The Association administered and collected funding for a catastrophic health insurance program. The Association charged a fee to any "insurer," "insurance arrangement" or "self insurer" that provided medical benefits. A self-funded ERISA plan alleged that ERISA pre-empted the Association from collecting the fee for the catastrophic health insurance program.

The court rejected defendant's arguments that the statute was too tenuously connected to ERISA to warrant preemption. In so doing, the court reasoned that the plan "indisputably affects the relations among the principal ERISA entities" because it compelled the ERISA plans to pay certain types of benefits. Moreover, the statute mandated the ERISA plan pay costs of people who were not beneficiaries of the plans. This further supported the court's finding. As in *Bricklayers*, the DRG scheme forces the Benefit Plans to structure themselves in a certain manner, and to pay hospital costs that accrue to nonbeneficiaries. Hence, the same reasons that compelled the *Bricklayers Local* court to pre-empt the state statute, apply to the instant case.

Once again, in *United Health Services, Inc. v. Upstate Administrative Services Inc.*, 151 Misc. 2d 783, 573 N.Y.S.2d 851 (Sup. Ct. Broome Cty. 1991), the court found that ERISA preempted New York's rate setting scheme. Under this scheme, plans covered by ERISA paid a DRG rate while other plans paid actual cost. In finding that the relationship between ERISA and the plan at issue was

not too tenuous, the court held that the statute subjected the ERISA plans to inconsistent regulations. *Cf. General Motors Corp. v. Caldwell*, 647 F. Supp. 585 (N.D. Ga. 1986) (statute that regulated rates for prescriptions pre-empted by ERISA. Although not explicitly directed at ERISA plans, statute created an administrative scheme with which ERISA regulated plans had to comply).

Here, as in *United Health Services*, the statute at issue would result in subjecting the Benefit Plan to inconsistent regulations. Such inconsistencies would thwart the purposes of ERISA to create benefit plans subjected to uniform regulation. Thus, as in *United Health Services*, this Court finds that ERISA pre-empts certain costs and methods included in New Jersey's hospital rate setting scheme.[16]

D. Constitutional Attacks

Plaintiffs further allege that the manner in which hospital rates are set under Chapter 83 violates both the United States's Constitution and the Constitution of the State of New Jersey. Specifically, plaintiffs contend Chapter 83 deprives them of their procedural and substantive due process rights and the equal protection rights guaranteed to them under the Constitutions of the United States and the State of New Jersey; it constitutes a taking of property without just compensation under the United States Constitution; it imposes a special tax law in violation of the New Jersey Constitution; and it violates the New Jersey Constitution because it delegates taxing power from the Legislature to the Commissioner.

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[16] Defendants argue that both *Bricklayers Local No. 1* and *United Health Upstate Administrative Services* are distinguishable from the case at bar because the state statute at issue in those cases directly affected the ERISA plans. In light of the previous discussion that the Supreme Court has refused to limit ERISA pre-emption to state laws that directly affect ERISA benefit plans, this Court finds that defendant's argument has no merit.

Additionally, defendants cite *Bonser v. New Jersey*, 605 F. Supp. 1227, 1232 (D.N.J. 1985), as in support of their position. In *Bonser* the court opined that ERISA probably would not pre-empt New Jersey's system for setting hospital rates according to DRG category and not according to actual cost. Defendants' reliance on *Bonser* is misplaced for two reasons. First, the *Bonser* decision pre-dated the Supreme Court's most recent pre-emption opinion. These opinions further expand § 514(a)'s scope. Second, the costs added to the DRG rate for indigent care, bad debts, and the medicare cost shift were not at issue in *Bonser*.

1. Denial of Equal Protection

Plaintiffs assert two ways in which the provisions of Chapter 83 violate their equal protection rights under both the United States Constitution and the Constitution of the State of New Jersey. First, plaintiffs argue that the costs included in the DRG rate for indigent care, hospitals' bad debts and, costs for the Medicare shortfall violate the equal protection clause because these costs are borne only by hospital patients and not by all New Jersey's residents. Second, plaintiffs contend that the 11% discounts which are only available to plans with open enrollment and, are therefore, not available to the Benefit Plans denies plaintiffs their equal protection rights.

A plaintiff who challenges a statute or regulation that neither regulates a suspect class nor burdens the exercise of a fundamental right has a heavy burden. A Court must uphold a statute as long as it is rationally related to a legitimate governmental interest. *New Orleans v. Dukes*, 427 U.S. 297, 302, 96 S. Ct. 2513, 2516-17 (1976).

In determining whether legislation has a rational relation to a legitimate governmental interest, a Court must "accord wide latitude [to states] in the regulation of their local economies under their police powers, and rational distinctions may be made with substantially less than mathematical exactitude." A court cannot "judge the wisdom or desirability of legislative policy determinations made in areas that neither affect fundamental rights nor proceed along suspect lines." *Id.* Only the "wholly arbitrary act" can be deemed irrational. *Id.*

Consistently, courts have upheld regulations that disparately affect different classes of payors when challenged under the equal protection clause. For example, in *Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 96 S. Ct. 2882, 2892-94 (1976), the Supreme Court upheld a federal statute that disparately charged different classes of mine workers for medical costs incurred by employees and former employees who contracted black lung disease. Under the statute, a miner's former employer had to pay the miner's medical expenses.

The employers argued that the statute denied them of due process

of law[17]; because it "spread costs in an arbitrary and irrational manner by basing liability upon employment relationships, rather than taxing all coal miine operators presently in business." 428 US. at 19; 96 S. Ct. at 2894. According to the employers, such an irrational statute compelled an operator who presently employed fewer people to be saddled with a liability which was disproportionate to the size of the employers current workforce. As a result, newer employers received a competitive edge and the older employers were unfairly apportioned a greater burden.

In holding that the statute had a rational basis, the Supreme Court gave great deference to Congress. In particular, the Court stated:

> [I]t is for Congress to choose between imposing the burden of inactive miners' disabilities on all operators, including new entrants and far-sighted early operators who might have taken steps to minimize black lung dangers, or to impose that liability solely on early operators whose profits may have been increased at the expense of their employees' health. . . . It is enough to say that the Act approaches the problem of cost spreading rationally;

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[17] The Supreme Court has declared that the due process clause of the Fifth Amendment contains an equal protection component applicable to actions in which a plaintiff challenges a United State's statute on the ground it treats different categories of people unfairly. The analysis under the due process clause is identical to the analysis under the equal protection clause of the Fourteenth Amendment. Plaintiffs contend that Chapter 83 arbitrarily discriminates among types of payors. In particular, plaintiffs declare that under Chapter 83 uninsured payors are charged "actual cost" but insured payors must pay the DRG cost that includes costs for the benefit of others. Plaintiffs assert that this violates their due process rights. Because plaintiffs challenge a state statute, plaintiffs should have asserted this cause of action under the equal protection clause.

Moreover, plaintiffs erroneously contend that all noninsured patients pay actual cost. Rather, only uninsured payors who successfully appeal pay actual costs. Therefore, this Court will construe plaintiffs claim as an equal protection challenge to the appeal process' differential treatment of insured and uninsured patients.

Even if plaintiffs alleged that the DRG costs violated their substantive due process rights because the charges deprived them of their property, this Court would still find that plaintiffs' claim was without merit. A substantive due process claim parallels a claim brought under the equal protection clause. In cases that do not implicate fundamental rights, the court must determine whether the regulation "is rationally related to furthering a legitimate state interest." *Meier v. Anderson*, 692 F. Supp. 546, 552 (E.D. Pa. 1988), *aff'd*, 869 F.2d 590 (3d Cir. 1989). As discussed in more detail below, the hospital rate setting system is rationally related to the furthering New Jersey's interest in containing hospital costs, ensuring hospitals remain financially solvent, and providing health care for its citizens. Therefore, a substantive due process claim would fail.

> whether a broader costspreading scheme would have been wiser or more practical under the circumstances is not a question of constitutional dimension.

See also United States v. Sperry Corporation, 493 U.S. 52, 110 S. Ct. 387 (1989) (due process challenge to statute that charged a fee to claimants who successfully recovered an award before the Iran-United States Claims Tribunal failed. Court found rational basis existed to compel only those who received a payment from the Tribunal to help subsidize the costs of running the Tribunal).

In the present case, the New Jersey Legislature has articulated a rational basis for the differential treatment given to plaintiffs. The Legislature has a rational basis for charging the cost of uncompensated care to plaintiffs. In accordance with its power to provide for the general welfare of its citizens, the Legislature has mandated that hospitals must provide care to anyone, regardless of ability to pay for the services. In order to follow this directive, Chapter 83 requires the DRG rate to include a charge for uncompensated care. Moreover, as part of its obligation to provide for the welfare of its citizens, one of Chapter 83's purposes is to ensure the economic solvency of its hospitals. Charging plaintiffs for uncompensated care is rationally related to both of these goals.

Although plaintiffs argue that this cost should be apportioned among all residents of New Jersey and not only among those who use the hospitals, this does not amount to a constitutional challenge. It is rational for New Jersey to force those who benefit from using the hospitals to bear the costs incurred by the hospitals for uncompensated care. Similarly, in order to provide for its citizens general welfare and to ensure the fiscal solvency of hospitals, it is rational for the Legislature to give discounts to plans that allow any citizen to enroll and to compel plans that do not have open enrollment to subsidize these discounts.

Finally, this Court finds that New Jersey's appeal procedure that effectively allows only uninsured patients to appeal the DRG charges that exceed the total cost by at least $250 has a rational basis. The appeal policy permits those who are more severely affected by hospital charges to obtain some financial relief. Thus, the process allows the State to provide for its citizens general welfare without overburdening a hospital's ability to remain fiscally solvent. For these reasons, this Court holds that plaintiffs' claims

brought under the Equal Protection Clause of the Federal Constitution have no merit.[18]

2. Taking of Property Without Just Compensation[19]

Plaintiffs further argue that the inclusion of certain costs in the DRG rate deprive plaintiffs of their property without just compensation. Consequently, plaintiffs contend these charges violate their rights under the Fifth Amendment which are applied to the states through the Fourteenth Amendment.

The Supreme Court has ruled that a statute or regulation which forces a person to expend money for the benefit of another does not constitute a physical taking of property. *See Sperry*, 493 U.S. 60, 110 S. Ct. 393 (1989); *Colorado Springs Production Credit Association v. Farm Credit Administration*, 758 F. Supp. 6, 12 (D.D.C. 1991). Accordingly, a regulatory takings analysis, and not a *per se* analysis applies to the regulations in the case at bar. *Colorado Springs Production Credit Association* at 12.

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[18] The courts apply the same analysis to claims that arise under New Jersey's equal protection clause as the courts apply to the equal protection clause contained in the Fourteenth Amendment. *See In Re C.V.S. Pharmacy Wayne*, 116 N.J. 490, 498 (1989), *cert. denied, Consumer Value Stores v. Board of Pharmacy*, 483 U.S. 1045 (1990) ("Legislation [will be] sustained if it is not arbitrary, capricious, or unreasonable, and the means selected bear a rational relationship to the legislative objective." . . . For a statute to be rationally related to the public interest, it need not be the best or only method of achieving the legislative purpose.") In fact, the New Jersey Supreme Court held that discounts given to Blue-Cross under the previous hospital rate setting scheme did not deny plaintiffs, a union health plan, their equal protection rights. Moreover, a due process analysis under the New Jersey Constitution follows an equal protection analysis. Therefore, plaintiffs' equal protection claims and due process claims fail under New Jersey's constitution for the same reasons that they are unfounded under the United States Constitution.

Additionally, New Jersey applies an equal protection analysis to determine whether a tax violates the State Constitution's prohibition against the levy of special taxes. *See Vreeland v. Byrne*, 72 N.J. 292, 298-99 (1977). Hence, in light of the above discussion even if under New Jersey law, the challenged costs were taxes, this Court would find that New Jersey has not imposed a special tax.

[19] The Hospital Defendants have instituted a counterclaim in which they allege that failing to increase hospital rates to compensate hospitals for the shortfall they face would constitute a taking of their property under both the United State's constitution and New Jersey's constitution. Assuming that plaintiffs have presented a ripe controversy to this Court, this Court finds that under the analysis announced by *Connolly*, losing their expected revenues does not constitute a taking of the Hospital Defendants' property. Likewise, this Court finds that the State Defendants inaction would not constitute a taking under the New Jersey Constitution.

There is no "set formula" that a court can apply to determine whether a regulation violates the Takings Clause. *Connolly v. Pension Guaranty Corp.*, 475 U.S. 211, 222, 106 S. Ct. 1018, 1025 (1986). Instead, courts determine whether a regulation violates the Takings Clause on an "ad hoc basis," in which the court focuses on "[the facts and] circumstances of each particular case." *Id.* The Supreme Court has announced a threeprong test to assist courts to decide whether a regulation constitutes a taking. Under this analysis the court considers:

> (1) the character of the governmental action; (2) the economic impact of the regulation on the claimant; and (3) the extent to which the regulation has interfered with investment backed expectations.

Id. at 1026 (citing) *Penn Central Transportation Co. v. New York City*, 438 U.S. 104, 124, 98 S. Ct. 2646, 2659 (1978).

The regulation at issue in *Connolly* required any employer who withdrew from a multi-employer fund to pay a fee that was related to an employers share of the plans "unfunded vested benefits." The regulation mandated such a fee in order to ensure that pension plans would be financed adequately.

Guided by this analysis, the *Connolly* court found that the federal regulation did not violate the takings clause. As to the type of governmental action, the Court found that this factor merited a finding that the regulation did not constitute a taking. Specifically, the Court found that the "Government [did] not physically invade or permanently appropriate any of the employer's assets for its own use." Instead, the government enacted the statute to protect participants in ERISA plans. The Court then concluded that "[such] an interference that adjusts the benefits and burdens of economic life to promote the common good [did] not constitute a taking." *Id.*

The Court then acknowledged that the regulation permanently deprived the plaintiff of any money it required him to pay. Nonetheless, the Court did not find that the regulation imposed a severe economic impact on plaintiffs. In so doing, the Court noted that the assessment on the employer related to the plans to which he had contributed. *Id.*

Finally, the Court found that the regulation failed to interfere with any of plaintiffs' investment backed expectations. In particular, the Court declared that pension plans were and had been regulated heavily by the Government. In light of the Court's findings, the Court held that the regulation did not violate plaintiffs rights under the takings clause.

Similarly, in *Meier v. Anderson*, 692 F. Supp. (E.D. Pa. 1988), the court found that the provision in Pennsylvania's Health Care Services Malpractices Act (the "Act") that established the Medical Profession Liability Catastrophe Loss Fund (the "CAT Fund") did not violate the takings clause. The Act required doctors to maintain malpractice insurance and to pay an annual surcharge to the CAT fund. This surcharge amounted to between 5% and 50% of a doctor's gross income and was calculated as a percentage of the Doctor's cost for malpractice insurance.

The Legislature enacted the surcharge to ensure adequate compensation to malpractice victims. The plaintiffs alleged that the surcharge violated their constitutional rights under the takings clause because it "placed the burden of compensating malpractice victims" on all doctors instead of on society in general or doctors who engaged in malpractice.

In reaching its decision, the court followed the analysis applied by the *Connolly* court. First, the court examined the type of action engaged in by the government. As in *Connolly*, the court found that Pennsylvania did not "physically invade or permanently appropriate any of plaintiffs' assets for its own use" but instead enacted a regulation that shifts economic burdens in order to "promote the common good."

Second, the court noted that as in *Connolly*, the Act permanently deprived the plaintiffs of the money that plaintiffs had to pay pursuant to the statute. The court further reasoned, however, that the regulation did not impose an arbitrary assessment upon plaintiffs. Instead, the assessment consisted of a percentage of a plaintiff's malpractice insurance costs. Furthermore, the court noted that plaintiffs benefitted from the Act. In particular, the Act excluded them from liability for malpractice claims that exceeded their insurance contributions.

Finally, the court concluded that plaintiffs had no reasonable investment backed expectations. First, the court explained that if the

Legislature had not passed the statute, plaintiffs would have expected to incur costs-for a malpractice judgment entered against them. Second, the court held that the state had regulated medicine over a long period of time. In view of these considerations, the court held the Act did not violate the takings clause.

In the instant case, as in the cases discussed above, plaintiffs have failed to show that the inclusion of certain costs in the DRG rate constitutes an unconstitutional taking of their property. New Jersey has not "physically invaded or permanently appropriated for its own use any of plaintiffs' assets." Instead, New Jersey has enacted Chapter 83 in order to promote the public good. Simply because this statute and the regulations promulgated under it, "adjusts the benefits and burdens of economic life," it is not transformed into a taking of plaintiffs property.

Furthermore, even though the statute permanently deprives plaintiffs of the costs associated with the DRG charges, this does not weigh in favor of this Court finding a taking. In particular, as in both *Connolly* and *Meier*, the amount of money exacted from plaintiffs is not determined on an ad hoc basis. The amount of money charged is directly related to the individual plaintiffs' hospital bill. Moreover, plaintiffs benefit from the Act for two reasons. First, it not only allows hospitals to maintain a higher level of care, but in some cases it also allows them to continue to provide health care. Moreover, the regulations would allow the individual plaintiffs to receive quality healthcare if they ever were unable to afford their hospital bills.

Finally, plaintiffs could not have had a reasonable investment backed expectation. New Jersey has regulated hospitals and hospital rates for many years. Moreover, even if New Jersey did not enact Chapter 83, hospitals would still charge plaintiffs for uncompensated care and the medicare differential so they could comply with their statutory obligation to provide hospital care for everyone regardless of that person's ability to pay. For these reasons, this Court finds that plaintiffs have failed to show that the costs included in the DRG rate rise to the level of an unconstitutional taking of property.[20]

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[20] This Court can dismiss summarily plaintiffs' procedural due process and illegal delegation of taxing power challenges to the DRG scheme. Plaintiffs' contend that the manner in which hospital rates are set constitutes an illegal delegation of

III. CONCLUSION

For the reasons expressed above, this Court grants defendants' motion for summary judgment as to defendants' state and federal constitutional claims. Further, this Court grants plaintiffs' motion for summary judgment as to the ERISA pre-emption claim. In particular, this Court finds ERISA pre-empts the sections of Chapter 83 and the corresponding regulations that mandate uncompensated care, allow the Medicare differential, allow the payor discounts, and allow for appeals of the DRG rate charged to a particular patient.

An appropriate order is attached.

Dated: May 27, 1992

ALFRED M. WOLIN, U.S.D.J.

(Continued)
the taxing power from the state to the Commissioner. Even if the charges included in the DRG rate constitute a tax under New Jersey law this court must dismiss plaintiffs' claim.

New Jersey has recognized that Legislatures have broad delegation powers. The Legislature must simply set out standards to guide the agency and its administrators. *Association of New Jersey College Facility, Inc. v. Board of Higher Education,* 112 N.J. Super. 237, 258 (Law Div. 1970). The rates at issue are set according to standards established by the Legislature and not determined solely at the whim of the Commissioner. In fact, the manner in which hospital rates are set has withstood these precise challenges. *In Re Schedule of Rates for Barnett Memorial Hospital,* 92 N.J. 31, 41-42 (1983); *In Re William B. Kessler Memorial Hospital,* 78 N.J. 564 (1979); *Borland v. Bayonne Hospital,* 72 N.J. 152, 158-59, *cert. denied,* 434 U.S. 817 (1977).

Additionally, even if plaintiffs challenge to the appeal process can be interpreted as a procedural due process claim, it would still fail. Plaintiffs have not established that New Jersey ever allowed them to receive the benefit of an appeal. Thus, New Jersey has never deprived plaintiffs of any benefit accorded them. Therefore, plaintiffs have no basis on which to advance a procedural due process claim to the appeal process.

United States District Court

FOR THE DISTRICT OF NEW JERSEY

UNITED WIRE, METAL & MACHINE HEALTH AND WELFARE FUND, et al.,

Plaintiffs,

v.

MORRISTOWN MEMORIAL HOSPITAL, et al.,

Defendants.

Civil Action No. 90-2639 (Consolidated)

ORDER

In accordance with the Court's Opinion filed herewith,

It is on this 27th day of May, 1992,

ORDERED that ERISA pre-empts the sections of Chapter 83, and the regulations promulgated thereunder, that allow for the inclusion of uncompensated care, the Medicare Cost Shift, Payor Discounts and appeals of the DRG rate for patients whose DRG rate exceeds total cost by at least $250.00; and it is further

ORDERED that the State Defendants are permanently enjoined from enforcing these provisions. This permanent injunction will take effect as of June 5, 1992; and it is further

ORDERED that this Court declines to exercise its pendent and supplemental jurisdiction over plaintiffs restitution claims; and it is further

ORDERED that plaintiffs' motion for summary judgment as to its state and federal constitutional claims is denied; and it is further

ORDERED that defendants' motion for summary judgment as to plaintiffs' state and federal constitutional claims is granted; and it is further

ORDERED that defendants' claim that this Court has no jurisdiction over this suit pursuant to the Tax Injunction Act is denied; and it is further

ORDERED that the State Defendants' immunity claim brought under the Eleventh Amendment is denied.

ALFRED M. WOLIN, U.S.D.J.

Nos. 93-115, 93-193, 93-194, 93-210

Supreme Court, U.S.
FILED
SEP 28 1993
OFFICE OF THE CLERK

In The

Supreme Court of the United States

October Term, 1993

NYSA-ILA WELFARE FUND, *et al.*,

Petitioners,

vs.

FRANCIS J. DUNSTON, in her capacity as NEW JERSEY COMMISSIONER OF HEALTH, *et al.*,

Respondents.

*On Petition for Writ of Certiorari to the United States Court of Appeals for the Third Circuit**

BRIEF IN OPPOSITION FOR RESPONDENT NEW JERSEY HOSPITAL ASSOCIATION AND THE RESPONDENT HOSPITALS

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* Case captions for additional petitions are referenced on inside front cover.

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NEW JERSEY CARPENTERS WELFARE FUND, *et al.*,

Petitioners,

vs.

FRANCES J. DUNSTON, in her capacity as NEW JERSEY COMMISSIONER OF HEALTH, *et al.*,

Respondents.

TRUSTEES OF THE WELFARE TRUST FUND, LOCAL UNION NO. 475, *et al.*,

Petitioners,

vs.

FRANCES J. DUNSTON, in her capacity as NEW JERSEY COMMISSIONER OF HEALTH, *et al.*,

Respondents.

UNITED WIRE, METAL & MACHINE HEALTH AND WELFARE FUND, *et al.*,

Petitioners,

vs.

MORRISTOWN MEMORIAL HOSPITAL, *et al.*,

Respondents.

QUESTIONS PRESENTED FOR REVIEW

1. Whether the Court of Appeals correctly applied this Court's prior precedents in holding that a generally applicable hospital rate setting statute which is not intended to regulate the conduct of self-insured employee benefit plans, does not single out such plans for special treatment, does not predicate rights and obligations upon the existence of such plans and does not dictate or restrict the manner in which such plans administer their affairs, is not preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq.*

2. Whether the Court of Appeals correctly applied this Court's prior precedents in holding that a generally applicable hospital rate setting statute which adjusts the benefits and burdens of economic life to promote the common good, does not impact upon plan participants in an inappropriate way and which constitutes a continuation of New Jersey's long standing regulation of health care matters, does not cause a taking of property without just compensation in violation of the Fifth Amendment of the United States Constitution.

PARTIES TO THE PROCEEDINGS

All parties to these proceedings appear in the caption of the decision of the United States Court of Appeals for the Third Circuit, which is contained in petitioners' appendix at pages A-1 through A-5. Because of the large number of parties, the list will not be reproduced herein. In accordance with Supreme Court Rule 29.1, a list of the respondents' parent corporations and subsidiary corporations that are not wholly owned is reproduced in the appendix to this brief.

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STATEMENT OF THE CASE

This case involves the issue of whether certain components of New Jersey's comprehensive statutory scheme governing hospital rate setting are preempted by ERISA, 29 U.S.C. § 1001, *et seq.*, or create an unlawful taking of property without just compensation in violation of the Fifth Amendment to the United States Constitution.

A. Hospital Rate-Setting in New Jersey

New Jersey's Health Care Facilities Planning Act, N.J.S.A. 26:2H-1, *et seq.* (the "Act") was enacted by the New Jersey Legislature in 1971.[1] The declared public policy underlying the Act was:

> that hospital and related health care services of the highest quality, of demonstrated need, efficiently provided and properly utilized at a reasonable cost are of vital concern to the public health.

N.J.S.A. 26:2H-1 (1992).[2] (Respondents' Appendix, *infra,* at A-8). In order to attain cost-containment and efficiency, the Act authorized the Commissioner of the New Jersey Department of

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1. On November 30, 1992, the Legislature enacted the Health Care Reform Act of 1992, L. 1992, ch. 160. As a result of this legislation, the State of New Jersey no longer regulates the establishment of hospital rates. While the specific statutory provisions challenged herein have been superseded, petitioners seek restitution of monies paid while those provisions were in effect, and many hospitals have not been paid in full for services rendered pending the final outcome of this litigation. As a result, the Court of Appeals determined that this case was not moot.

2. Pertinent sections of the Act have been reproduced in respondents' appendix.

Health (the "Commissioner") to regulate certain costs of health care services, including the establishment of hospital rates. N.J.S.A. 26:2H-5, 26:2H-18, and 26:2H-18.1 (1992) (Resp. A-15-23).

As originally enacted in 1971, the Act authorized the Commissioner to set hospital rates only for individuals whose care was paid for by Blue Cross and certain governmental programs, such as Medicaid. L. 1971, c. 136, § 18. (Resp. A-23-24). The rates were based on the actual cost of services provided by hospitals, a method which furnished only limited incentives to improve efficiencies in hospital operation. Under the 1971 Act, the state had no authority over the rates that hospitals charged patients who had private insurance coverage or the uninsured. Consequently, these groups sometimes paid higher rates for the same services. *See generally Borland v. Bayonne Hospital,* 72 N.J. 152, 159 (1977), *cert. denied,* 434 U.S. 817 (1977).

In order to achieve greater control over the increasing cost of hospital services, reduce the disparity in rates charged to patients whose care was fully or partially paid for by different payors, and alleviate the financial burden on hospitals serving indigent patients, the New Jersey Legislature amended the Act by establishing a new system of hospital rate-setting controlling charges to all patients receiving hospital services. L. 1978, c. 83.[3] Unlike the former system, Chapter 83 applied to all payors, not just to individuals whose care was paid for by Blue Cross and Medicaid. Chapter 83 contained an express recital that cost containment was a stated objective of the Act. N.J.S.A. 26:2H-1 (1992). (Resp. A-8). The statute also had an express goal of promoting the fiscal solvency of hospitals. *Id.* Administration of the new rate-setting system was delegated to the New Jersey Department of Health ("DOH").

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3. These amendments have become known as "Chapter 83".

The rate-setting system set a prospective rate of reimbursement, in advance of actual treatment, which was a blend of the statewide mean/standard costs developed by looking at the resources consumed by the industry as a whole and the hospital-specific resources and costs consumed in treating particular illnesses, categorized as diagnosis related groups ("DRG"). N.J.A.C. 8:31B-5.1. Each DRG reflected a wide variety of both direct and indirect patient care costs. N.J.A.C. 8:31B-3.4. These costs were derived from actual costs incurred by all acute care hospitals during a particular base year, as updated for inflation and certain other factors. N.J.A.C. 8:31B-2.5.[4] The quantification of these costs into certain "financial elements" were used to develop each hospital's "preliminary cost base" and schedule of rates. N.J.A.C. 8:31B-3.16.

The "preliminary cost base" was defined as that portion of a hospital's actual, current costs which may reasonably be required to be reimbursed to a properly utilized hospital for the efficient and effective delivery of appropriate and necessary health care services of high quality required by such hospital's mix of patients. N.J.S.A. 26:2H-2.k (1992). (Resp. A-11). Each hospital received a blend of its own costs and the mean/standard costs developed by looking at the hospital industry as a whole. N.J.A.C. 8:31B-3.5. Direct patient care costs in excess of the blend of the hospital's own costs and the mean/standard costs were "disincentives" which were excluded from a hospital's rates. Where, however, a hospital's costs were below the standard, the hospital nevertheless

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4. In employing a DRG-based methodology, New Jersey's hospital rate-setting system was similar to the hospital reimbursement system employed by the Medicare program. Indeed, Medicare's DRG-based methodology was developed as a result of a review of demonstration projects employing this methodology undertaken by the States of New Jersey and New York under the authority of the Secretary of the U.S. Department of Health and Human Services. *See* H.R. Rep. No. 25, 98th Cong., 1st Sess. 145, *reprinted in* 1983 U.S. Code Cong. & Ad. News 143, 364.

received a proportion of the standard costs, thereby gaining an increase or "incentive" in its rates. N.J.A.C. 8:31B-3.23(a).

The prospective nature of the rate-setting system and its reliance on illness-related diagnosis related groups precluded the establishment of rates that relied on a particular individual's length of stay, treatment and consumption of resources. For example, if a patient was admitted for an appendectomy, a hospital could only charge the patient the amount approved for the DRG classification of appendectomy, and not the actual cost of all services provided to the patient. Thus, the amount approved for a DRG classification could actually be lower or higher than the actual cost of the services that the patient received.

Each hospital's schedule of rates, defined as the amount which each hospital was permitted to charge per DRG, was approved by New Jersey's Hospital Rate Setting Commission ("HRSC"), at a level sufficient to generate the amount of revenue required to cover the revenue requirements of the preliminary cost base.

1. Uncompensated Care

Among the costs of doing business incurred by hospitals operating within New Jersey are costs associated with the provision of services to individuals who are unable to pay. These costs are known as uncompensated care costs, incurred as a result of a statutory requirement which specified that "access to quality health care shall not be denied to residents of the state because of their inability to pay for the care." L. 1991, c. 183, § 1. (Resp. A-24-25). Federal law similarly requires treatment of such patients. Under 42 U.S.C. § 1395dd, hospitals must treat and stabilize individuals in need of emergency care and women in active labor regardless of whether or not they can pay. In addition, a state licensure standard, N.J.A.C. 8:43G-5.2(c), specifies that hospitals "shall not deny admission to patients on the basis of their inability

to pay", while N.J.A.C. 8:43G-4.1(a)2 requires every New Jersey hospital patient be accorded the right to "treatment and medical services without discrimination based on race, age . . . ability to pay, or source of payment."

When Chapter 83 was originally enacted, uncompensated care costs which a particular hospital incurred were borne entirely by that particular hospital's patients. Each hospital factored in uncompensated care costs as a component of its rates in order to meet this cost of doing business. As a result, hospitals serving a large population of indigent patients were forced to charge significantly higher rates than hospitals providing less uncompensated care. The provision of a high proportion of uncompensated care threatened the financial stability of hospitals with high uncompensated care case loads.

New Jersey's hospital reimbursement system sought to alleviate the financial burdens imposed on hospitals through their provision of unreimbursed care by requiring the cost of providing such care to be considered in hospital rates charged to all patients. Thus, N.J.S.A. 26:2H-18.d expressly provided that the reasonable costs of hospital services to indigent patients and bad debts were mandatory financial elements of a hospital's preliminary cost base which were to be included in the rates charged to all non-federal payors. (Resp. A-20).

Monies utilized to reimburse hospitals for the provision of uncompensated care were collected through the imposition of a uniform charge which was added to each patient's hospital bill. The uniform charge amounts collected from all patients were then remitted by the hospitals to a Trust Fund. All monies remitted to the Fund were appropriated to the state Medicaid agency, which would then reimburse hospitals for the amount of uncompensated care that they actually provided.

2. The Medicare Cost Shift

Under N.J.S.A. 26:2H-18.1.c. (1992) (Resp. A-22), hospital rates were also permitted to account for adjustments that resulted from statutes and regulations affecting the delivery of health care. Such adjustments were required to take into account the effectiveness and efficiency of the health care delivery system as a whole. The federal Medicare program does not pay the same rates as were provided for under the New Jersey DRG reimbursement system, since Medicare payment rates are established under a separate federal statutory scheme. *See* 42 U.S.C. § 1395c *et seq.* Accordingly, DOH created adjustments in the rates paid by non-Medicare patients to account for the shortfall between what Medicare would pay and the New Jersey DRG rate. N.J.A.C. 8:31B-3.73. This was known as the "Medicare cost shift."

3. Payor Differentials

The HRSC was also permitted to grant differentials in payment rates to a payor or class of payors. N.J.S.A. 26:2H-18.b (1992) (Resp. A-18-19). If the HRSC granted a payor differential, it had to be supported by evidence of "quantifiable economic benefits rendered to the institution or to the health care delivery system taken as a whole." Under the authority of this provision, a differential from the DRG rate was accorded to patients who had health benefits coverage through certain payors, such as Blue Cross and Blue Shield, as a result of the financial benefits to society which are provided by the open enrollment programs offered by such payors. The differentials were allocated among patients covered by all payors other than Medicare so that a hospital received from all payors net revenue equal to its preliminary cost base.

B. ERISA Preemption

The Employee Retirement Income Security Act, popularly

known as ERISA, 29 U.S.C. § 1001, *et seq.*, was enacted in 1974. The subject of the ERISA statute is pension benefit plans and employee benefit plans. ERISA contains a preemption clause which provides that ERISA "shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan" which is covered by ERISA. 29 U.S.C. § 1144(a).[5] The statute defines the term "state" to include any political subdivision, agency or instrumentality of a state, while state law was defined to include all laws, decisions, rules or regulations or other state action having the effect of law. 29 U.S.C. §§ 1144(c)(1), 1144(c)(2).

C. Decisions Below

Commencing in 1990 and continuing through the first half of 1992, over a dozen self-insured employee benefit plans ("the Plans") and a number of individual Plan participants commenced a series of civil actions (later consolidated) against the State of New Jersey and most of the state's acute care hospitals seeking an injunction against the application to them of New Jersey's hospital rate setting statute. The Plans and their participants alleged that certain provisions of the statutes and regulations applicable to hospital rate setting were preempted by ERISA, denied the Plans and their participants due process and equal protection under the New Jersey and United States Constitutions, violated the Fifth Amendment of the United States Constitution by creating a taking of property without just compensation, and created an unlawful tax and delegation of taxing authority. In particular, the Plans challenged the inclusion in hospital rates of: (1) the uncompensated care add-on; (2) the Medicare cost shift; and (3) payor differentials.

On May 27, 1992, the District Court issued an Opinion and Order which provided for the entry of a permanent injunction

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5. This provision is also referred to as Section 514(a).

against the state defendants. (Pet. A-64-95). The District Court enjoined enforcement of New Jersey's hospital rate setting statute and regulations to the extent that they allowed for the inclusion in hospital rates charged to ERISA-covered plan participants of costs attributable to the provision of uncompensated care, the Medicare cost shift and payor differentials. While the court acknowledged that no court had extended ERISA preemption to the extent of its opinion, the court found that New Jersey's hospital rate setting statute "related to" ERISA plans, even though the statute did "not mention benefit plans directly and [did] not regulate the terms and conditions of any such plans explicitly". (Pet. A-80). The court rejected the plans' constitutional claims. (Pet.A-85-92). The injunction was stayed pending appeal. (Pet. A-19).

On May 14, 1993, the Court of Appeals reversed the decision of the District Court. (Pet. A-1-61). The Court of Appeals concluded that New Jersey's hospital rate setting law constituted a generally applicable law which (1) is not intended to regulate the affairs of ERISA plans; (2) neither singles out such plans for special treatment nor predicates rights or obligations on the existence of an ERISA plan; and (3) does not have the effect of either dictating or restricting the manner in which ERISA plans structure or conduct their affairs or impairing their ability to operate simultaneously in more than one state. The Court of Appeals expressed an unwillingness "to attribute to Congress and Section 514 an intent to frustrate the efforts of the State, under its police power, to regulate health care costs." The court concluded that it had found no case that had held a law fitting the characteristics of the New Jersey hospital rate setting statute to be preempted by ERISA, and it would decline to so hold. (Pet. A-30).

The Third Circuit also soundly rejected the Plans' claims that the challenged costs did not constitute an unlawful taking of property without just compensation and affirmed the District Court's summary judgment for the defendants as to the Plans'

constitutional claims.[6] (Pet. A-22-23).

REASONS FOR DENYING THE WRIT

I.

REVIEW BY THIS COURT IS NOT AVAILABLE BECAUSE THE COURT OF APPEALS HAS NOT DECIDED A FEDERAL QUESTION IN A WAY THAT CONFLICTS WITH APPLICABLE DECISIONS OF THIS COURT.

Under Rule 10.1(c) of the Rules of the Supreme Court, a Petition for a Writ of Certiorari may be granted if a United States Court of Appeals has decided a federal question in a way that conflicts with applicable decisions of this Court. No such conflict has occurred as a result of the Third Circuit's decision in *United Wire*. Petitioners' efforts to convince this Court otherwise misconstrues the Court's earlier, consistent holdings that only state statutes which impact on ERISA benefit plans, not plan benefits or plan beneficiaries, are subject to preemption by ERISA.

Under ERISA preemption analysis, a law "relates to" an employee benefit plan if it has a connection with or reference to such a plan. *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 96-97 (1983). A state law that either directly or indirectly refers to, or otherwise attempts to or succeeds in regulating or interfering in the administration of employee benefit plans, relates to ERISA and is preempted. *Fort Halifax Packing Company, Inc. v. Coyne*, 482 U.S. 1, 7-8 (1987). As recently as last term, however, this Court reiterated that preemption does not occur if a state law has only a "tenuous, remote or peripheral connection with covered plans, . . . as is the case with many laws of general applicability." *District of*

6. Petitioners' equal protection, due process and tax law claims were neither raised nor considered on appeal.

Columbia v. Greater Washington Board of Trade, 113 S. Ct. 580, 583 n. 1 (1992). *See also Ingersoll- Rand v. McClendon,* 498 U.S. 133, 139 (1990); *Shaw,* 463 U.S. at 100, n. 21.

Under the plain language of the statute and this Court's precedents, there *must* be a nexus between the ERISA-covered plan and the state statute, regulation or cause of action being challenged. In the absence of such a nexus, there can be no finding of ERISA preemption. For example, in *Fort Halifax,* this Court declined to find preemption of a Maine statute requiring employers to provide a one-time severance payment to employees in the event of a plant closing. As the Court noted, a crucial feature of ERISA's preemption provision is its deliberate use of the term "employee benefit plan." While the appellants in *Fort Halifax* argued that any state law pertaining to an employee benefit listed in ERISA necessarily regulates an employee benefit plan, the Court rejected this distinction, finding the choice of words employed by Congress to be deliberate:

> Nothing in our case law, however, supports appellant's position that the word "plan" should in effect be read out of the statute . . . The words "benefit" and "plan" are used separately throughout ERISA, and nowhere in the statute are they treated as the equivalent of one another. Given the basic difference between a "benefit" and a "plan", Congress' choice of language is significant in its preemption of only the latter.

Fort Halifax, 482 U.S. at 8. Similarly, in *Mackey v. Lanier Collection Agency,* 486 U.S. 825 (1988), this Court refused to find George's general garnishment statute to be preempted, even though the statute at issue prevented plan participants from receiving their benefits and even though complying with garnishment orders might burden the administration of the plan.

In *Ingersoll-Rand Company v. McClendon,* 498 U.S. 133 (1990), this Court considered a state cause of action which allowed former employees to bring wrongful discharge suits based upon the fact that the alleged reason for discharge was a desire not to make payments to the employee out of an employee benefit plan. Although the Court concluded that the state cause of action was preempted by ERISA, the Court nevertheless reiterated that there are limits to ERISA preemption. The Court reaffirmed its earlier determination in *Fort Halifax* that under the plain language of the ERISA statute, only state laws that relate to benefit *plans* are preempted. *Ingersoll-Rand,* 498 U.S. at 139. The Court also noted that under its decision in *Mackey,* the fact that collection might burden the administration of a plan did not, by itself, compel preemption. In finding that the state cause of action considered in *Ingersoll-Rand* was preempted by ERISA, the Court drew the following distinction between laws that are preempted by ERISA and those that are not:

> We are not dealing here with a generally applicable statute that makes no reference to, or indeed functions irrespective of, the existence of an ERISA plan, nor is the cost of defending this lawsuit a mere administrative burden. Here, the existence of a pension plan is a critical factor in establishing liability under the state's wrongful discharge law.

Id. at 139-140. Thus, the Court did not retreat from its earlier holdings that ERISA preemption is not without limits and that laws which operate irrespective of the existence of ERISA plans can survive a preemption challenge.

The Third Circuit's decision is entirely consistent with this Court's prior decisions regarding the scope of ERISA preemption. The court analyzed the impact that New Jersey's rate setting statute had on ERISA plans and concluded that the requisite nexus

between the challenged statute and the plans was lacking in this case. This was entirely appropriate, since all that New Jersey's hospital rate setting scheme did was to establish a methodology of setting hospital rates which calculated the price charged to hospital patients for the services that they received irrespective of whether or not they possessed health benefits coverage.[7] As the Third Circuit correctly found, New Jersey's hospital rate setting statute never dictated what an employee benefit plan must pay, and did not require ERISA plans to cover a plan participant's total hospital costs. Under the statutory and regulatory scheme, plans remained free to set their benefit levels without any reference to the state-regulated DRG rate, and were free to pay whatever portion of an individual's hospital bill they deemed appropriate.[8] While the rate-setting system did impact upon the price for hospital services paid by plan participants, the system did not impose any requirements on the plan itself.

Petitioners argue that there is a direct impact on the plan because of the economic impact that payment of the challenged

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7. Even individuals who were uninsured had amounts attributable to uncompensated care, the Medicare cost shift and payor differentials included in the rates they were charged by hospitals.

8. The provision of uncompensated care originates in part from federal requirements specifying that hospitals must provide indigent care. 42 U.S.C. § 1395dd mandates hospitals to treat and stabilize individuals experiencing emergency conditions (including women in active labor) irrespective of their ability to pay. In addition, regulations under the federal Hill-Burton program preclude hospitals receiving Hill-Burton funding from denying emergency services to persons residing in the facility's service area due to an inability to pay. *See* 42 C.F.R. § 124.603. The uncompensated care add-on represented a mechanism developed by the state to compensate hospitals for the costs of providing these services. It would be inconsistent to find that one federal law would preclude hospitals from recovering revenues needed to comply with the requirement that they provide uncompensated care at the same time that another federal law mandates that hospitals provide such care.

add-ons had on the plan and plan participants. This overlooks the fact that this Court has never found a statute to be preempted simply because it increases the price paid by plan participants for a particular commodity.[9]

Petitioners' analysis reflects a fundamental misunderstanding of the mechanics of setting a price for hospital services. The cost of providing uncompensated care and of discounts provided to certain payors is no different from any other type of cost that hospitals incur. As the Third Circuit accurately observed, a state's imposition of this cost of doing business is:

> No different in kind, however, from any state regulation that increases the cost of goods or services that hospitals consume and pass on in hospital costs, i.e. utility costs, the wages of its employees, waste disposal costs, etc.

(Pet. A-26). In this regard, hospitals function just like any other business, where prices established include not only operating expenses but sufficient markup to cover theft, spoilage and discounts provided to wholesale customers or during promotional events. The payment of these costs does not constitute a payment for the benefit of others, as petitioners allege, but merely represents reimbursement to the hospitals to cover their costs of doing business.

The fact that compliance with a state statute might indirectly increase plan costs was held not to be a sufficient ground for

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9. Petitioners assert that New Jersey's statute thwarted the express purpose of their plans because many plans have a purpose of paying 100% of a participant's hospital bill. While this is a laudable goal, the State cannot be required to set hospital rates at a level that will permit third party payors to cover the full amount of a patient's bill. The issue raised by petitioners is an economic issue, not an ERISA preemption issue.

preemption in this Court's earlier decision in *Mackey,* where a Georgia garnishment law was found not to be preempted by ERISA despite the fact that "substantial administrative burdens and costs" were incurred by the plans in complying the statute. *Mackey,* 486 U.S. at 831-32. Given the result in *Mackey,* the Third Circuit's conclusion that New Jersey's statute is not preempted despite the fact that it may increase the charges billed to ERISA plan participants for hospital services is entirely consistent with this Court's prior decisions in this area.

No hospital bill purports to represent the actual cost of treating a particular individual. There are many types of costs incurred by hospitals that must be passed on to their patients which do not necessarily relate to the specific resources that the particular patient consumes. For example, hospital rates include amounts attributable to capital costs incurred by hospitals for improvements to a hospital facility. If a hospital constructs a pediatrics wing, it can include some of the costs attributable to this construction and the debt service payments associated with it in its rates. Thus, a 45 year old hospitalized for knee surgery may be paying a small portion of the costs attributable to the construction of a new pediatrics wing in his rates, even though this individual would not receive any services in that wing. The Third Circuit concluded that it is impossible for hospitals to set their prices in such a way as to only provide a bill for the specific services rendered to an individual patient. (Pet.A-31). This conclusion does not conflict with any prior decision by this Court. Nothing in this Court's earlier decisions can be read as standing for the proposition that ERISA plan participants may only be required to pay those components of a price which relate specifically to identifiable goods and services actually consumed by the plan participant.

The petitioners candidly admit that they do not challenge the underlying DRG reimbursement feature of New Jersey's hospital reimbursement statute, an admission that is fraught with an inherent and obvious contradiction. Under the DRG system, a

price was set for a particular type of service irrespective of the length of time that the patient stays in the hospital. Thus, a patient hospitalized for an appendectomy would receive the same bill irrespective of whether the patient stayed in the hospital 2, 4 or 6 days, absent any complicating factors which would have justified an additional payment. Because this system is based on an average cost per case, and not the actual cost incurred by a particular patient, utilization of a DRG system means that all patients will have costs included in their hospital rates which are attributable to others. Indeed, participants in the petitioners' plans directly benefited from this system of averages if they stayed in the hospital longer than the average period of time for a particular DRG, since the DRG would be calculated based upon a review of the costs associated with the average number of days of hospitalization for that illness. The very foundation of a DRG-based system is the provision of positive and negative incentives for hospitals to reduce costs. Petitioners cannot be permitted to selectively retain the benefits of the state's efforts to make health care affordable, while avoiding any perceived burdens in participating in the system. In either case, the State's pricing structure affects the relationship between the hospital and the plan participant, not the relationship between the hospital and the plan.

Petitioners assert that they are forced to subject their plan to conflicting forms of administration and that they are forced to abide by inconsistent regulations. However, the record is devoid of any evidence that hospital rates are uniform among all other states, and that New Jersey is somehow unique. The cause of the administrative difficulties and inconsistencies referenced by petitioners does *not* flow from the peculiar features of New Jersey's hospital rate setting system, but the fact that hospital prices can vary substantially among different states, or even within different geographic regions of a particular state. Hospital rates will, of necessity, be affected by such varying factors as differences in wage costs, as well as differences in the price of purchasing the commodities used by hospitals. As the Third Circuit

noted, the petitioners would always be subject to these inherent inconsistencies, regardless of the nature of the reimbursement system utilized or the components contained therein.

The petitioners' flawed analysis also overlooks the fact that the challenged components of the DRG rate are components of hospital rates in all states, not just New Jersey. Several other states which regulate hospital rate-setting include the cost of providing uncompensated care in the rates. *See, e.g.*, N.Y.P.H.L. § 2807-c. The Third Circuit's conclusion that state regulation of hospital pricing is not likely to make interstate operation of an ERISA plan more difficult is entirely consistent with this Court's prior decisions. This Court has never held that either ERISA-covered plans or their participants must be permitted to pay the same price for a particular service in different states, even though there may be legitimate reasons for prices varying from one state to another. Hospitals which set their own rates in a non-regulated setting include costs attributable to charity care, bad debt, Medicare shortfalls and payor discounts in their rates as costs of doing business. Indeed, the District Court acknowledged this by stating that "Even if New Jersey did not enact Chapter 83, hospitals would still charge plaintiffs for uncompensated care . . . so that they could comply with their statutory obligations to provide hospital care for everyone regardless of that person's ability to pay." (Pet.A-92). It defies logic to suggest that costs which would normally be included in hospital charges in the absence of state regulation cannot be included in the rates charged to ERISA plan participants if the same costs are established pursuant to state statute. To find New Jersey's system to be preempted by ERISA would raise a serious question regarding the ability of a state to take *any* action regarding regulation of hospital rates, since the mere action of setting rates which will be paid by participants in ERISA-covered plans could arguably cause such plans to structure benefits in a particular manner.

Petitioners assert that because the statute includes a reference

to "union welfare plan identification cards", the statute expressly references ERISA plans and is therefore preempted. The reference in question simply provides that a hospital shall not be reimbursed for the cost of providing uncompensated care unless it interviews each patient admitted to determine whether the patient is covered by health insurance, as documented by such items as "a union welfare plan identification card or claim form." N.J.S.A. 26:2H-18.31. All that the statute does is require verification of whether third party insurance is available to pay all or part of a patient's bill. It does not regulate the amount of coverage or set the rate that must be paid, and does not impose any additional burdens upon plan administrators. In short, this provision causes no impact on the plan at all, whether direct or indirect. Thus, as the Third Circuit correctly found, this reference should be regarded as without legal consequence for preemption purposes, and is therefore distinguishable from the references contained in the statutes analyzed by this Court in its *FMC* and *District of Columbia* decisions.[10]

Petitioners also contend that their participants derived no benefit from the existence of the challenged components in New Jersey's hospital rates and that their participants bore a disproportionate share of the burden in covering these costs. It is not true that plan participants derived no benefit from inclusion of these costs in hospital rates. Without coverage of these legitimate business costs, hospitals could not survive. Therefore, plan participants did derive a direct benefit from these costs because payment of these costs helped to provide hospitals with sufficient cash flow to keep their doors open.

New Jersey's hospital rate setting statute did place a large

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10. The references to self-funded union plans in the Department of Health's Patient Appeal Policy also should not result in a finding of preemption. The Patient Appeal Policy does not regulate the plans or the rates they are charged, or cause any impact on the plan administrator.

share of the burden of paying for uncompensated care upon individuals who have the resources to pay for such care. However, while the fact that individuals who pay for hospital services bear a larger share of the overall cost of providing such services may be unfair or debatable from a social policy point of view, this does not give rise to a violation of ERISA. Plainly, ERISA does not address the rights of plan participants as consumers. As this Court has repeatedly held, the only impact the ERISA preemption provision is concerned with is the impact that a statute or a state cause of action has on the plan itself. The Third Circuit's decision is, therefore, in full accord with this Court's prior decisions respecting ERISA preemption, since the Third Circuit concluded that any impact on the plan itself, a necessary prerequisite to a finding of ERISA preemption, was absent here.

II.

THE THIRD CIRUIT'S DECISION IS NOT IN CONFLICT WITH THE DECISION OF ANOTHER UNITED STATES COURT OF APPEALS.

Under Supreme Court Rule 10.1(a), this Court may exercise its discretion and grant a Petition for a Writ of Certiorari when a United States Court of Appeals has rendered a decision in conflict with the decision of another United States Court of Appeals on the same matter. The requisite conflict between the Circuits is lacking in this case. The only Court of Appeals decision to address an issue similar to those present in this case was *Rebaldo v. Cuomo*, 749 F.2d 133 (2nd Cir. 1984), a case whose reasoning was followed by the Third Circuit in reaching its decision in *United Wire*. While petitioners may seek to characterize other cases as being in conflict with the decision of the Third Circuit, these cases are either trial court decisions or deal with different issues and, therefore, do not create a direct conflict.

Rebaldo is the only Court of Appeals decision which deals

with the issue of ERISA preemption in the context of a review of a hospital rate setting statute. The statute at issue in *Rebaldo* prohibited hospitals from establishing inpatient charges for self-insured employee benefit plans that were different than the charges authorized by a state statute. The Second Circuit sustained the New York statute against an ERISA preemption challenge. The Second Circuit's decision in *Rebaldo* was premised upon two findings: (1) that a state statute cannot be found to be preempted by ERISA unless it "purports to regulate the terms and conditions of an employee benefit plan" and (2) that a state statute which constitutes a generally applicable exercise of a state's police powers should not be found preempted by ERISA if it only affects a plan in a tenuous, peripheral or remote manner. The Third Circuit followed the second prong of the *Rebaldo* court's analysis. Thus, there is uniformity among the circuits with respect to the issue of whether a generally applicable hospital rate-setting statute should be viewed as preempted by ERISA.

Petitioners attempt to gloss over the fact that no conflict between the circuits is present here by arguing that the decision in *Rebaldo* has been effectively overruled by subsequent decisions of this Court and other lower courts. *Rebaldo* and *United Wire* are the only circuit court decisions dealing specifically with the issue of whether a generally applicable hospital rate setting statute is preempted by ERISA. Even if it were assumed for the sake of argument that *Rebaldo* was no longer good law, all that this would mean is that *United Wire* would stand on its own as the only Court of Appeals decision dealing with this particular issue. Thus, the requisite conflict between the circuits would still be lacking.

Moreover, the portion of the *Rebaldo* decision upon which the Third Circuit relied has not been overruled. The *Rebaldo* court's first rationale for finding no preemption has been narrowed by this Court's decision in *Ingersoll-Rand,* which held that a state cause of action which was predicated on the existence of an employee benefit plan could be preempted even if it did not purport to

regulate the terms and conditions of ERISA plans. However, the Supreme Court has not overruled the second and more important prong of the Second Circuit's analysis in *Rebaldo*. The state cause of action at issue in *Ingersoll-Rand* was not a generally applicable law which functioned irrespective of the existence of an ERISA plan. Indeed, both in *Ingersoll-Rand* and the more recent *District of Columbia* decision, this Court was careful to make an express note of the fact that it was *not* dealing with a generally applicable statute which affected a plan in a "tenuous, remote or peripheral" manner. Thus, *Rebaldo* has not been overruled by subsequent decisions of this Court.

The portion of the *Rebaldo* holding relied on by the Third Circuit has also never been overruled by the Second Circuit. In *Aetna Life Insurance Company v. Borges*, 869 F.2d 142 (2nd Cir. 1989), *cert. denied*, 493 U.S. 811 (1989), the Second Circuit reaffirmed this portion of its *Rebaldo* holding. While there is a footnote in the Second Circuit's decision in *Smith v. Dunham- Bush Inc.*, 959 F.2d 6, 9 n.3 (2nd Cir. 1992) referencing *Rebaldo*, the Court noted only that *Rebaldo* could no longer be invoked for the proposition that a state law is preempted "only if it relates to and *purports to regulate an ERISA plan*." (Emphasis in original). However, the court in *Smith* never addressed *Rebaldo's* holding that a generally applicable state law cannot be preempted if its relationship with an ERISA plan is too tenuous, remote or peripheral to satisfy the "relate to" test.

Petitioners attempt to create a conflict between the circuits where none exist by arguing that several courts have found state laws to be preempted even where they can be categorized as generally applicable state laws involving an exercise of the state's police powers. These cases do not involve an exercise of the state's police power to regulate health care matters, and while the statutes analyzed in these other cases were generally applicable exercises of the state's police power, they had a concrete and direct impact on the plan. Thus, the decisions in these cases have not overruled the

portion of the *Rebaldo* decision relied on by the Third Circuit, and do not create a conflict either with *Rebaldo* or with the Third Circuit's decision in *United Wire*.

For example, in *General Electric v. Department of Labor*, 891 F.2d 25 (2d Cir. 1989), the Second Circuit held that a state law which required an employer to either bring the cost of its prescribed benefits into equivalence with the cost of local prevailing benefits or to pay the additional cost directly to employees was preempted by ERISA. However, while a labor law could be characterized as a generally applicable exercise of the state's police powers, the majority opinion in *General Electric* did not analyze the statute's status as such a law. Moreover, the law's affect on the plan was neither tenuous nor remote, because the plan was specifically told that it either had to pay benefits or maintain detailed records showing that another form of equivalent compensation was provided. In contrast, New Jersey's hospital rate setting system neither required plans to provide a particular level of benefits nor required a plan to establish how its participants' health care costs are otherwise being paid for.

In *Arkansas Blue Cross and Blue Shield v. St. Mary's Hospital*, 947 F.2d 1341 (8th Cir. 1991), *cert. denied*, 112 S. Ct. 2305 (1992), the Eighth Circuit held that an Arkansas statute that allowed a plan participant to assign benefits to health care providers, thus forcing plans to honor all assignments of benefits made by plan participants, was preempted by ERISA. While the court stated in its opinion that a state law's relationship to traditional state authority was not relevant to the question of whether a state statute relates to ERISA plans, the court went on to determine that this factor "is a policy consideration useful in deciding borderline questions of ERISA preemption," and analyzed the state statute at issue by reviewing the state's interest in enforcing it. *Arkansas Blue Cross*, 947 F.2d at 1350. Moreover, unlike the statute at issue in this case, the statute analyzed in *Arkansas Blue Cross* directed

plan administrators where benefits could be paid. This was a direct requirement imposed on the plans, and thus clearly could not be said to impact plans in a tenuous or remote manner.

The Eighth Circuit relied on *Gilbert v. Burlington Industries, Inc.*, 765 F.2d 320, 327 (2nd Cir. 1985) and *Boise Cascade Corporation v. Peterson*, 939 F.2d 632 (8th Cir. 1991) as authority for its conclusion in the *Arkansas Blue Cross* case regarding ERISA preemption. In both of these cases, however, the courts found that in order to avoid preemption, a statute representing the exercise of a traditional police power must *also* affect a plan in only a tenuous, remote or peripheral manner. *Gilbert*, 765 F.2d at 327, *Boise Cascade*, 939 F.2d at 639. This is the same reasoning utilized by the *Rebaldo* court. These cases similarly cannot be relied on as authority for the proposition that a conflict in the circuits exists regarding *Rebaldo's* enduring premise.[11]

Petitioners also rely on several lower court decisions where a generally applicable hospital rate setting law was found preempted and argue that a conflict is created by the existence of these decisions. First of all, the existence of these cases does not warrant further review by this Court, since this Court's rules do not permit the Court to exercise its discretion and grant a Petition for a Writ of Certiorari when there is a conflict between a Court of Appeals and a

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11. Petitioners also reference *Bricklayers Local No. 1 v. Louisiana Health Insurance*, 771 F. Supp. 771 (S.D. La. 1991), a District Court case. There, a Louisiana statute required plans to pay a $2 service charge as part of an individual's hospital bill. The funds were utilized to fund a catastrophic health insurance program. The Louisiana statute made the patient's insurance arrangement directly responsible for payment of the service charges and further required that payment of these charges had to be a "mandated benefit covered by an individual's insurance plan." The District Court decided that the statute was preempted. The Louisiana statute did not affect the plans in a tenuous or peripheral manner, since the service charge was levied directly on the plan, and the plan had no discretion as to whether to pay it or not.

lower court. Secondly, the analysis employed to strike down the hospital rate setting statutes at issue in each of these cases is seriously flawed.

In *Traveler's Insurance Company v. Cuomo*, 813 F. Supp. 996 (S.D.N.Y. 1993), *appeal pending*, No. 93-7194 (2nd Cir.), a federal District Court in New York invalidated certain aspects of New York's hospital rate setting scheme on ERISA preemption grounds and expressly stated that it would not follow *Rebaldo*. However, the District Court's decision in that case relied heavily on the decision of the District Court in the within matter, which was subsequently reversed by the Third Circuit. Petitioners also reference the state trial court decision in *United Health Services, Inc. v. Upstate Administrative Services*, 573 N.Y.S. 2d 851 (Sup. Ct. Broome Cty. 1991). The reasoning in *United Health* was based on a flawed premise. The court concluded that plan administrators were subjected to conflicting state regulations by virtue of the challenged statutory provision, since a plan which limited payment to the reimbursement of "actual expenses" would provide a different percentage level of coverage in New York than in a state that did not set reimbursement rates as New York did. This analysis presupposed that hospital rates in all states would have to be set in an identical manner in order to withstand scrutiny under ERISA, and overlooks the fact that things such as wage rates, material costs and the costs of doing business can differ dramatically in different parts of the United States.

Because there is no conflict between the circuits as to the portion of the *Rebaldo* holding relied on by the Third Circuit, and because this portion of the *Rebaldo* court's decision has not been overruled, it is clear that petitioners cannot demonstrate the existence of a conflict between the circuits which would justify the grant of their petition for a Writ of Certiorari.

III.

THE THIRD CIRCUIT'S DISPOSITION OF THE NYSA-ILA WELFARE FUND'S TAKINGS CLAIM IS IN FULL CONFORMITY WITH STANDARDS PREVIOUSLY DELINEATED BY THIS COURT.

Both the District Court and the Court of Appeals concluded that the inclusion of certain costs in the state regulated rates charged by New Jersey hospitals did not deprive petitioners of their property without just compensation in violation of the Fifth Amendment. Petitioner NYSA-ILA Welfare Fund has sought Supreme Court review of the lower courts' disposition of this issue. Since the lower courts decided this issue in conformity with existing Supreme Court precedent, there is no conflict between the Third Circuit's decision and existing decisions of this Court. In addition, there is no Court of Appeals decision which conflicts with the Third Circuit's resolution of this issue, and it does not raise an important question of federal law which has not previously been addressed by this Court. Therefore, no further review by this Court is available.

N.J.S.A. 26:2H-18.d (1992) provided that the reasonable cost of hospital services to indigent patients, as well as bad debts, were to be included as mandatory financial elements of a hospital's preliminary cost base. (Resp. A-20-21). Clearly, the inclusion of such costs in hospital rates does not amount to a physical taking of property. As a result, a less stringent "regulatory takings" analysis, rather than a per se takings analysis, applies to the statutes and regulations being challenged by petitioners. *Concrete Pipe and Products v. Construction Laborers Pension Trust,* 113 S. Ct. 2264, 2290 (1993).

This Court has held that the takings clause is not violated simply because legislation requires one person to use his or her assets for the benefit of another. *Connolly v. Pension Benefit*

Guaranty Corp., 475 U.S. 211, 223 (1986). Moreover, requiring money to be spent in a particular way does not constitute a taking. *See United States v. Sperry Corporation*, 493 U.S. 52 (1989); *Atlas Corp. v. United States*, 895 F.2d 745, 756 (Fed. Cir. 1990), *cert. denied*, 498 U.S. 811 (1990). Evaluation of whether governmental regulation of property constitutes a taking requires an ad hoc factual inquiry into the circumstances of each case. *Connolly*, 475 U.S. at 224. This Court has identified three factors which are to be analyzed in making such a determination. These are: (1) the character of the governmental action; (2) the economic impact of the regulation on the claimant; and (3) the extent to which the regulation has interfered with distinct investment-backed expectations. *Penn Central Transportation Company v. New York City*, 438 U.S. 104, 124 (1978).

The nature of the challenged governmental action here is the inclusion of uncompensated care costs and the costs of the Medicare shortfall and payor differentials in the hospital bills given to all patients. In order to enable hospitals to remain in operation and to provide care to all in need of hospital services, the state reasonably determined that the costs of this care should be spread among all hospital patients. As a result, the Third Circuit concluded that New Jersey's rate system merely "adjusts the benefits and burdens of economic life to promote the common good," a factor which militates against the finding that a taking has occurred. *Concrete Pipe*, 113 S. Ct. at 2290, *quoting Connolly*, 475 U.S. at 225.

Petitioner asserts that a taking occurred because the uncompensated care add-ons paid by ERISA plan participants were paid into a fund managed and controlled by a state bureaucracy. The utilization of this mechanism by the state plainly does not result in the permanent appropriation of private assets. The trust fund mechanism referred to was merely a conduit utilized to fairly distribute collected uncompensated care monies to

hospitals.[12] These monies were not retained by the state. Monies attributable to the Medicare cost shift and payor differentials went directly to hospitals as a component of their hospital rates, and therefore cannot be considered to be appropriated by the state for its own use.

As both the District Court and the Court of Appeals found, plan participants received a clear, specific economic benefit from New Jersey's hospital rate setting system. Therefore, the system's economic impact on them is not so severe as to justify a finding that a taking has occurred. The amount of money paid by plan participants is not determined on an ad hoc basis, since amounts attributable to uncompensated care, the Medicare cost shift and payor differentials were directly related to an individual plan participant's hospital bill. Even in the absence of state regulation of hospital costs, hospitals would have to recoup these costs, because they would go out of business if they failed to do so. By ensuring the recovery of such costs and enabling hospitals to stay in business, New Jersey's hospital rate setting scheme thus protected the interests of ERISA plan participants (and users of hospital services generally) in maintaining access to health care. In addition, to the extent that individual plan participants might not have sufficient assets to pay their full hospital bill, the inclusion of the costs attributable to bad debts within hospital rates would have resulted in coverage of a portion of their bills.

Because hospital rate setting has long been heavily regulated on both the federal and state levels due to its technical complexity, the District Court and Court of Appeals were correct in finding that New Jersey's hospital rate setting statute did not interfere with "reasonable investment-backed expectations." As this Court has

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12. Petitioner's oblique reference to the state's use of the trust fund mechanism as a vehicle for obtaining federal matching funds from the Medicaid program is irrelevant to a takings analysis, as such funds are clearly not private monies.

previously held, reasonable investment-backed expectations under the takings clause must amount to more than a "unilateral expectation." *Webb's Fabulous Pharmacies v. Beckwith*, 449 U.S. 155, 161 (1980).

New Jersey's inclusion of uncompensated care costs and costs attributable to the Medicare cost shift and payor differentials was a long standing feature of New Jersey's state regulated hospital rate setting system. More importantly, as the District Court expressly found, if hospitals established their rates under a free market, competitive system, the challenged components could clearly be included as a portion of the hospital's overall reasonable charge. (Pet. A-92). Given the mechanics of hospital pricing, petitioners cannot reasonably assert that they have a vested right in having the hospital rates they pay exclude such costs.

Since the Third Circuit's decision conforms with prior decisions of this Court as to petitioner's takings claims, there is no valid reason for this Court to revisit the conclusions reached by the lower courts as to these claims.

IV.

THIS CASE DOES NOT PRESENT AN IMPORTANT QUESTION OF FEDERAL LAW WHICH SHOULD BE SETTLED BY THIS COURT.

Petitioners urge the Court to grant their Petitions because of the current national interest in health care reform. They also contend that the Court needs to review this case because of pending legislative initiatives in a number of states concerning hospital rate setting.

No matter how much interest may be engendered by health care issues at the moment, these circumstances clearly do not

warrant this Court's review. First of all, this case does not present a novel issue that has not previously been addressed by the Supreme Court. While the specific, narrow issue of ERISA preemption in the context of hospital rate setting has not been addressed, this Court has had occasion to review the general question of whether a state statute should be found preempted by ERISA numerous times. In deciding these cases, the Court has fashioned a test which requires that the state statute must impact upon the ERISA plan, rather than plan participants or plan benefits, in order for it to be found preempted. All that the Third Circuit did was to apply the analysis previously reached by the Court in these cases in concluding that New Jersey's hospital rate setting statute did not impact upon the plan in a manner which would require preemption.

The significance of the Third Circuit's decision has largely been eclipsed by subsequent developments in New Jersey. The State of New Jersey deregulated hospital rate setting effective January 1, 1993. *L.* 1992, c. 160. As a result, any decision the Court might reach would have no impact whatsoever on the establishment of hospital rates in New Jersey, since that function is no longer state regulated. The only remaining "live" issue between the parties relates to the question of whether plans should have to pay the full DRG rate for services rendered during the period that this litigation was ongoing. While final resolution of this issue might be important to the individual parties from a financial perspective, it clearly does not present the Court with an ongoing issue of such national importance that review by this Court is warranted.

Finally, the fact that there are pending legislative initiatives with respect to the issue of hospital rate setting in a number of states does not warrant further review by this Court. While health care reform may indeed be a pressing national issue, this court is not in the business of rendering advisory opinions. Yet this is tantamount to what petitioners are seeking when they requested review of this case because of pending state legislative initiatives.

Given the large number of federal court decisions in existence where an ERISA preemption claim was addressed, it is more than likely that this Court will have the opportunity to revisit the limits of its prior preemption decisions again in the future. Accordingly, this is not a case which presents a special or novel issue that would warrant Supreme Court review.

CONCLUSION

Because petitioners have failed to establish that they meet the requirements for the grant of a Petition for a Writ of Certiorari, it is respectfully requested that the Court deny the Petitions for a Writ of Certiorari.

Respectfully submitted,

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APPENDIX A — CORPORATE DESIGNATION OF RESPONDENTS

In accordance with Rule 29.1, respondents state that they have the following corporate parent-subsidiary relationships:

1. Atlantic City Medical Center; No parent or subsidiaries.

2. Nathan and Miriam Barnert Memorial Hospital d/b/a Barnert Hospital; No parent or subsidiaries.

3. Bayonne Hospital; No parent or subsidiaries.

4. Bayshore Community Hospital; Parent - Bayshore Health Care Services, Inc.; No subsidiaries.

5. Burdette Tomlin Memorial Hospital; Parent - Cape Health System, Inc.; No subsidiaries.

6. Chilton Memorial Hospital; Parent - Memorial Health Foundation (formerly known as Chilton Memorial Corporation); No subsidiaries.

7. Christ Hospital; Parent - Christ Hospital Health Services Corporation; No subsidiaries.

8. Clara Maass Medical Center; Parent - Clara Maass Health Systems, Inc.; No subsidiaries.

9. Community Medical Center; Parent - Community Memorial Health Services; No subsidiaries.

10. Cooper Hospital/University Medical Center; Parent - Cooper Health Care; No subsidiaries.

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11. Deborah Heart and Lung Center; No parent or subsidiaries.

12. Dover General Hospital & Medical Center; Parent - Lake Area Health System; No subsidiaries.

13. East Orange General Hospital; Parent - Essex Valley Health Care; No subsidiaries.

14. Englewood Hospital and Medical Center; Parent - Englewood Health Care Foundation, Inc.; No subsidiaries.

15. Hackensack Medical Center; Parent - Hillcrest Health Service System, Inc.; No subsidiaries.

16. Hackettstown Community Hospital; No parent or subsidiaries.

17. Helene Fuld Medical Center; Parent - Helene Fuld Healthcare; No subsidiaries.

18. Holy Name Hospital; No parent or subsidiaries.

19. Hunterdon Medical Center; Parent - Hunterdon Healthcare System, Inc.; No subsidiaries.

20. Irvington General Hospital; Parent - Beth Health Care Services Corporation; No subsidiaries.

21. Jersey Shore Medical Center; Parent - Modern Health Affiliates, Inc.; No subsidiaries.

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22. Community Hospital Group, Inc. d/b/a The JFK Medical Center; Parent - JFK Health Systems; No subsidiaries.

23. Kennedy Memorial Hospitals-University Medical Center; Parent - Kennedy Health Care Foundation; No subsidiaries.

24. William B. Kessler Memorial Hospital; No parent or subsidiaries.

25. Kimball Medical Center; Parent - Kimball Health Care Corporation; No subsidiaries.

26. The Medical Center of Ocean County, Inc.; Parent - The Ocean Health System, Inc.; No subsidiaries.

27. The Mercer Medical Center; No parent or subsidiaries.

28. Memorial Hospital of Burlington County; Parent - Memorial Health Alliance, Inc.; Subsidiary - Women's Auxiliary Board to Memorial Hospital of Burlington County.

29. Monmouth Medical Center; Parent - Mid-Atlantic Health Group, Inc.; No subsidiaries.

30. Morristown Memorial Hospital; Parent - Memorial Health Foundation, Inc.; No subsidiaries.

31. The Mountainside Hospital; Parent - Mountainside Hospital Healthcare, Inc.; No subsidiaries.

32. Muhlenberg Regional Medical Center; Parent - The Huntington Foundation; Subsidiaries - Muhlenberg Auxiliary, Inc.; and Muhlenberg Foundation, Inc.

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33. Newark Beth Israel Medical Center; Parent - Beth Health Care Services Corporation; No subsidiaries.

34. New Jersey Hospital Association; No parent or subsidiaries.

35. Newton Memorial Hospital; Parent - North Jersey Health Care Corp.; No subsidiaries.

36. The Hospital Center at Orange; No Parent; Subsidiaries - HCO Plus; Meals on Wheels; Orange Mountain Health Care; OMH Services; Zorah; and 323 Central Avenue.

37. Our Lady of Lourdes Medical Center; Parent - Our Lady of Lourdes Health Care Services, Inc.; Subsidiaries - Osborne Family Health Center, Inc.; and Our Lady of Lourdes School of Nursing.

38. Overlook Hospital; No parent or subsidiaries.

39. Palisades General Hospital; No parent or subsidiaries.

40. Pascack Valley Hospital; Parent - Well Care Group, Inc.; No subsidiaries.

41. The General Hospital Center of Passaic; Parent - Healthcare Continuum, Inc.; No subsidiaries.

42. The Medical Center at Princeton; No parent or subsidiaries.

43. Rahway Hospital; Parent - Recovery Healthsystems, Inc.; No subsidiaries.

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44. Raritan Bay Medical Center; Parent - Raritan Bay Health Service Corporation; No subsidiaries.

45. Riverview Medical Center; Parent - Riverview Health Care

46. Robert Wood Johnson University Hospital; Parent - RWJ Healthcare Corporation; No subsidiaries.

47. Kennedy Memorial Hospitals at Saddle Brook, Inc.; Parent - Kessler Rehabilitation Corporation; No subsidiaries.

48. Shore Memorial Hospital; Parent - Shore Memorial Health Foundation, Inc.; No subsidiaries.

49. Somerset Medical Center; Parent - Somerset Health Care Corporation; No subsidiaries.

50. South Amboy Memorial Hospital; Parent - South Amboy Memorial Hospital Association; No subsidiaries.

51. South Jersey Hospital System; Parent - Cooperative Health Care of Southern New Jersey, Inc.; Subsidiary - Community Health Care, Inc.

52. St. Barnabas Medical Center; Parent - St. Barnabas Corporation; No subsidiaries.

53. St. Clare's/Riverside Medical Center; Parent - SSM Healthcare Ministry Corporation; No subsidiaries.

54. St. Elizabeth Hospital; No parent or subsidiaries.

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55. St. Francis Hospital; Parent - Franciscan Health System of New Jersey, Inc.; No subsidiaries.

56. St. James Hospital; Parent - Cathedral Health Services, Inc.; No subsidiaries.

57. St. Joseph's Hospital & Medical Center; No parent or subsidiaries.

58. St. Mary Hospital; Parent - Franciscan Health System of New Jersey, Inc.; No subsidiaries.

59. St. Michael's Medical Center; Parent - Cathedral Health Services, Inc.; No subsidiaries.

60. St. Peter's Medical Center; No parent or subsidiaries.

61. Union Hospital; Parent - Mega Source, Inc.; No subsidiaries.

62. United Hospitals Medical Center; No parent or subsidiaries.

63. Underwood-Memorial Hospital; Parent - Underwood-Memorial Health Systems, Inc.; No subsidiaries.

64. The Valley Hospital; Parent - Valley Care Corp.; Subsidiary - Valley Health Services, Inc.

65. Wallkill Valley Hospital & Health Centers; Parent - Sisters of Sorrowful Mothers; No subsidiaries.

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66. Warren Hospital; Parent - Warren Hospital Health Services Corporation; No subsidiaries.

67. Wayne General Hospital; Parent - North Jersey Meditech; No subsidiaries.

68. West Hudson Hospital; Parent - Trico Health Care, Inc.; No subsidiaries.

69. West Jersey Hospital; Parent - West Jersey Health System; No subsidiaries.

70. Zurbrugg Memorial Hospital; Parent - Zurbrugg Health Foundation; No subsidiaries.

APPENDIX B — STATUTES REFERENCED

N.J.S.A. 26:2H-1

26:2H-1. Declaration of policy

It is hereby declared to be the public policy of the State that hospital and related health care services of the highest quality, of demonstrated need, efficiently provided and properly utilized at a reasonable cost are of vital concern to the public health. In order to provide for the protection and promotion of the health of the inhabitants of the State, promote the financial solvency of hospitals and similar health care facilities and contain the rising cost of health care services, the State Department of Health, which has been designated as the sole agency in this State for comprehensive health planning under the "National Health Planning and Resources Development Act of 1974" (Federal Law 93-641),[1] as amended and supplemented, shall have the central, comprehensive responsibility for the development and administration of the State's policy with respect to health planning, hospital and related health care services and health care facility cost containment programs, and all public and private institutions, whether State, county, municipal, incorporated or not incorporated serving principally as residential health care facilities, nursing or maternity homes or as facilities for the prevention, diagnosis, or treatment of human disease, pain, injury, deformity or physical condition, shall be subject to the provisions of this act.

N.J.S.A. 26:2H-2

26:2H-2. Definitions

The following words or phrases, as used in this act, shall have the following meanings, unless the context otherwise requires:

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1. 42 U.S.C.A. § 300k et seq.

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a. "Health care facility" means the facility or institution whether public or private, engaged principally in providing services for health maintenance organizations, diagnosis of treatment of human disease, pain, injury, deformity or physical condition, including, but not limited to, a general hospital, special hospital, mental hospital, public health center, diagnostic center, treatment center, rehabilitation center, extended care facility, skilled nursing home, nursing home, intermediate care facility, tuberculosis hospital, chronic disease hospital, maternity hospital, outpatient clinic, dispensary, home health care agency, residential health care facility and bioanalytical laboratory (except as specifically excluded hereunder) or central services facility serving one or more such institutions but excluding institutions that provide healing solely by prayer and excluding such bioanalytical laboratories as are independently owned and operated, and are not owned, operated, managed or controlled, in whole or in part, directly or indirectly by any one or more health care facilities, and the predominant source of business of which is not by contract with health care facilities within the State of New Jersey and which solicit or accept specimens and operate predominantly in interstate commerce.

b. "Health care service" means the preadmission, outpatient, inpatient and postdischarge care provided in or by a health care facility, and such other items or services as are necessary for such care, which are provided by or under the supervision of a physician for the purpose of health maintenance organizations, diagnosis or treatment of human disease, pain, injury, disability, deformity or physical condition, including, but not limited to, nursing service, home care nursing and other paramedical service, ambulance service, service provided by an intern, resident in training or physician whose compensation is provided through agreement with a health care facility, laboratory service, medical social

service, drugs, biologicals, supplies, appliances, equipment, bed and board, but excluding services provided by a physician in his private practice or by practitioners of healing solely by prayer, and services provided first aid rescue and ambulance squads as defined in the "New Jersey Safety Highway Act of 1971," P.L. 1971, c. 351 (C. 27:5F-1 et seq.).

c. "Construction" means the erection, building, or substantial acquisition, alteration, reconstruction, improvement, renovation, extension or modification of a health care facility, including its equipment, the inspection and supervision thereof; and the studies, surveys, designs, plans, working drawings, specifications, procedures, and other actions necessary thereto.

d. "Board" means the Health Care Administration Board established pursuant to this act.

e. "Commission" means the Hospital Rate Setting Commission established pursuant to this act.

f. "Government agency" means a department, board, bureau, division, office, agency, public benefit or other corporation, or any other unit, however described, of the State or political subdivision thereof.

g. "Statewide Health Coordinating Council" means the Statewide Health Coordinating Council formed under the provisions of Federal Law 93-641, as amended and supplemented.[1]

h. "Health Systems Agency" means an officially recognized health systems agency formed under the provisions of Federal law 93-641 as amended and supplemented.[2]

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1. 42 U.S.C. A. § 300k et seq.

2. 42 U.S.C.A. § 300*l*-1

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i. "Department" means the State Department of Health.

j. "Commissioner" means the State Commissioner of Health.

k. "Preliminary cost base" means that proportion of a hospital's current cost which may reasonably be required to be reimbursed to a properly utilized hospital for the efficient and effective delivery of appropriate and necessary health care services of high quality required by such hospital's mix of patients. The preliminary cost base initially may include costs identified by the commissioner and approved or adjusted by the commission as being in excess of that proportion of a hospital's current costs identified above, which excess costs shall be eliminated in a timely and reasonable manner prior to certification of the revenue base. The preliminary cost base shall be established in accordance with regulations proposed by the commissioner and approved by the board.

l. "Certified revenue base" means the preliminary cost base adjusted by the commission, as appropriate and necessary pursuant to regulations proposed by the commissioner and approved by the board, to provide for the financial solvency of a hospital which is properly utilized and which delivers, effectively and efficiently, appropriate and necessary health care services of a high quality required by its mix of patients.

m. "Provider of health care" means an individual (1) who is a direct provided of health care service in that the individual's primary activity is the provision of health care services to individuals or the administration of health care facilities in which such care is provided and, when required by State law, the individual has received professional training in the provision of such services or in such administration and is licensed or certified

for such provision or administration; or (2) who is an indirect provider of health care in that the individual (a) holds a fiduciary position with, or has a fiduciary interest in, any entity described in subparagraph b(ii) or subparagraph b(iv); provided, however, that a member of the governing body of a county or any elected official shall not be deemed to be a provider of health care unless he is a member of the board of trustees of a health care facility or a member of a board, committee or body with authority similar to that of a board of trustees, or unless he participates in the direct administration of a health care facility; or (b) received, either directly or through his spouse, more than one-tenth of his gross annual income for any one or more of the following:

(i) Fees or other compensation for research into or instruction in the provision of health care services;

(ii) Entities engaged in the provision of health care services or in research or instruction in the provision of health care services;

(iii) Producing or supplying drugs or other articles for individuals or entities for use in the provision of or in research into or instruction in the provision of health care services;

(iv) Entities engaged in producing drugs or such other articles.

n. "Private long-term health care facility" means a nursing home, skilled nursing home or intermediate care facility presently in operation and licensed as such prior to the adoption of the 1967 Life Safety Code by the State Department of Health in 1972 and which has a maximum 50-bed capacity and which does not accommodate Medicare or Medicaid patients.

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N.J.S.A. 26:2H-4.1

26:2H-4.1. Hospital rate setting commission

a. There is hereby established in the State Department of Health a Hospital Rate Setting Commission which shall consist of five members, three of whom shall be appointed by the Governor with the advice and consent of the Senate for terms of 4 years. Of the initial appointees, one shall serve for a term of 2 years and one for a term of 3 years. No member shall be eligible for appointment for more than two full consecutive terms. Two of the members appointed by the Governor shall be consumers of health care services who are not providers of health care services, and one shall have experience in hospital administration or finance. The Commissioners of the State Departments of Health and Insurance or their designated representatives, who shall be officials with the rank of deputy or assistant commissioner, shall serve as ex-officio voting members of the commission. The commission shall annually select a chairman from among its members. Three members of the commission shall constitute a quorum and no action of the commission shall be taken except upon the affirmative vote of a majority of its members.

The appointed members of the commission shall each receive compensation at $150.00 per day. The commission members shall also be entitled to reasonable expenses incurred in the performance of their duties. Any such member may be removed from office by the Governor, for good cause shown. Any vacancy occurring in the membership of the commission for any cause shall be filled in the same manner as the original appointment but for the unexpired term only. A member shall otherwise continue to serve after expiration of his term until a new appointment is made.

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The commission shall select an executive secretary and the commissioner shall provide to the commission such clerical staff, supplies and equipment as may be necessary for it to faithfully discharge its duties.

The commission shall be established and its members appointed by January 1, 1979.

b. The commissioner shall determine the order in which hospitals shall have their preliminary cost base and appropriate schedule of rates approved by the commission. The commissioner shall propose and the commission approve or adjust the preliminary cost base, and the commission shall approve an appropriate schedule of rates for all hospitals by January 1, 1983. The schedule of rates shall be reasonable and sufficient to provide the revenue requirements of the preliminary cost base and shall be adjusted from time to time, as appropriate, to reach the certified revenue base.

The commission shall certify the revenue base, provided the conditions described in subsections k. and *l.* of section 2 of this act has been met, and shall perform such other duties as are specified elsewhere in this act.

A hospital shall continue to be reimbursed under the rate setting system in effect on the day preceding the effective date of this act, except as said system is amended by regulation, until the commission approves the hospital's preliminary cost base.

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N.J.S.A. 26:2H-5

26:2H-5. Powers of commissioner

a. The commissioner, to effectuate the provisions and purposes of this act, shall have the power to inquire into health care services and the operation of health care facilities and to conduct periodic inspections of such facilities with respect to the fitness and adequacy of the premises, equipment, personnel, rules and bylaws and the adequacy of financial resources and sources of future revenues.

b. The commissioner, with the approval of the board, shall adopt and amend rules and regulations in accordance with the Administrative Procedure Act, P.L. 1968, c. 410 (C. 52:14B-1 et seq.) to effectuate the provisions and purposes of this act, including but not limited to: (1) the establishment of requirements for a uniform Statewide system of reports and audit relating to the quality of health care provided, health care facility utilization and costs; (2) certification by the department of schedules of rates, payments, reimbursement, grants and other charges for health care services as provided in section 18; and (3) standards and procedures relating to the licensing of health care facilities and the institution of additional health care services.

c. The commissioner may enter into contracts with any government agency, institution of higher learning, voluntary nonprofit agency, or appropriate planning agency or council; and such entities are authorized to enter into contracts with the commissioner to effectuate the provisions and purposes of this art.

d. The commissioner may provide consultation and assistance to health care facilities in operational techniques,

including but not limited to, planning, principles of management, and standards of health care services.

e. At the request of the commissioner, health care facilities shall furnish to the Department of Health such reports and information as it may require to effectuate the provisions and purposes of this act, excluding confidential communications from patients.

f. The commissioner may institute or cause to be instituted in a court of competent jurisdiction proceedings to compel compliance with the provisions of this act or the determinations, rules, regulations and orders of the commissioner.

g. Notwithstanding any rules and regulations governing private long-term health care facilities and enforcing the 1967 Life Safety Code, as amended and supplemented, the commissioner shall permit third floor occupancy of such facilities by owners, members of their immediate families, and licensed professionals employed at such facilities.

N.J.S.A. 26:2H-12

26:2H-12. Health care facility; requirements for operation; license; application; fees; issuance; renewals

a. No health care facility shall be operated unless it shall: (1) possess a valid license issued pursuant to this act, which license shall specify the kind or kinds of health care services the facility is authorized to provide; (2) establish and maintain a uniform system of cost accounting approved by the commissioner; (3) establish and maintain a uniform system of reports and audits meeting the requirements of the commissioner; (4) prepare and review

annually a long range plan for the provision of health care services, which plan shall be compatible with the State Health Plan established pursuant to the "National Health Planning and Resources Development Act of 1974" (Federal Law 93-641)[1] as related to medical health services, health care services, and health manpower; and (5) establish and maintain a centralized, coordinated system of discharge planning which assures every patient a planned program of continuing care and which meets the requirements of the commissioner which requirements shall, where feasible, equal or exceed those standards and regulations established by the Federal Government for all federally-funded health care facilities but shall not require any person who is not in receipt of State or Federal assistance to be discharged against his will.

b. (1) Application for a license for a health care facility shall be made upon forms prescribed by the department. The department shall charge such nonrefundable fees for the filing of an application for a license and any renewal thereof, as it shall from time to time fix in rules or regulations; provided, however, that no such fee shall exceed $2,000.00. The application shall contain the name of the health care facility, the kind or kinds of health care service to be provided, the location and physical description of the institution, and such other information as the department may require. (2) A license shall be issued by the department upon its findings that the premises, equipment, personnel, including principals and management, finances, rules and bylaws, and standards of health care service are fit and adequate and there is reasonable assurance the health care facility will be operated in the manner required by this act and rules and regulations thereunder.

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1. 42 U.S.C.A. § 300K et seq.

c. A license issued before the effective date of this act to a health care facility for its operation, upon the first renewal date thereafter, may be extended for a 1 year period of time, provided the facility then meets the requirements for licensure at the time said license was issued and submits an acceptable plan to meet current requirements at the end of said period of time.

N.J.S.A. 26:2H-18

26:2H-18. Payments by government agency or hospital service corporation; determination of rates

a. No government agency and no hospital service corporation organized under the laws of the State and no other purchasers of health care services shall purchase, pay for or make reimbursement or grant-in-aid for any health care service provided by a health care facility unless at the time the service was provided, the health care facility possessed a valid license or was otherwise authorized to provide such service.

b. Payment by government agencies other than those made through the Medical Assistance and Health Services Act, P.L. 1968, c. 413 (C. 30:4D-1 et seq.), and payment by hospital service corporations organized under the laws of this State for health care services provided by a hospital shall be at reasonable rates approved by the commission as provided for by regulations proposed by the commissioner and approved by the board.

The schedule of rates shall be reasonable and sufficient to provide the revenue requirements of the certified revenue base of a hospital, considering the health care system as a whole and based on financial elements approved by the commissioner. Nothing herein shall be construed to prohibit the Commissioner of Human

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Services from contracting with the Commissioner of Health for the commission to approve rates, on behalf of the Commissioner of Health, by which hospitals are reimbursed pursuant to the Medical Assistance and Health Services Act, P.L. 1968, c. 413 (C. 30:4D-1 et seq.). Rates of payment by hospital service corporations organized under the law of this State for health care services provided by a hospital shall be set by the commission. Payment by all other purchasers of health care services provided by a hospital shall be at reasonable rates approved by the commission as provided in this act. All payment rates shall be equitable for each payor or class of payors without discrimination or individual preference except for quantifiable economic benefits rendered to the institution or to the health care delivery system taken as a whole. In addition to other such benefits which the commission may consider, it shall consider the following, if found to be quantifiable: (1) degree of promptness and volume of payments to hospitals so that hospitals are provided with funds for current financing of their services; and (2) broad provision of health insurance coverages which are not otherwise affordable or obtainable at premium rates which are not self-supporting. In determining the quantifiable economic benefits to which consideration shall be given in approving payment rates, the commission may consider overall financial benefits to society which are provided by programs offered by a payor or class of payors.

c. Payment by government agencies other than those made through the Medical Assistance and Health Services Act, P.L. 1968, c. 413 (C. 30:4D-1 et seq.), and payment by hospital service corporations organized under the laws of this State for health services provided by health care facilities other than hospitals shall be at reasonable rates set by the commissioner based on financial elements approved by him; provided, however, that nothing herein

shall be construed to prohibit the Commissioner of Human Services from contracting with the commissioner for the setting of rates by which health care facilities other than hospitals are reimbursed pursuant to the Medical Assistance and Health Services Act, P.L. 1968, c. 413 (C. 30:4D-1 et seq.). Rates of payment by hospital service corporations organized under the laws of this State for health care services provided by a health care facility other than hospitals shall be set in consultation with the Commissioner of Insurance.

d. The financial elements of the preliminary cost base and of the certified revenue base shall include the reasonable cost of the following, as defined in regulations proposed by the commissioner and approved by the board: direct patient care; principal and interest payments; paid taxes, excluding income taxes; educational, research and training programs, not otherwise paid for by the State; the provision of health care services to individuals unable to pay for them for reasons of indigency; bad debts, provided adequate recovery procedures are followed; preservation, replacement and improvement of facility and equipment subject to appropriate planning requirements; and reasonable working capital. Said financial elements may include, where applicable and appropriate, a reasonable return on investment where a hospital is operating efficiently and effectively. In determining proposed payments to hospitals, the commissioner shall take into account a facility's income from all sources, including specific purpose grants and other funds from governmental sources, but excluding income and principal from board or donor restricted funds, gifts and special fund raising projects.

To establish and maintain a fair and equitable system for determining such payments, the commissioner shall require each

health care facility to report such financial, statistical and patient information as may be required, in accordance with a uniform system of reporting established by him. The commissioner may propose regulations for approval by the board which assess penalties for failure to report such information within such time as may be prescribed therein.

N.J.S.A. 26:2H-18.1

26:2H-18.1. Preliminary cost base, certified revenue base or schedule of rates; adjustments; determination and review by commission; regulations

a. The commission shall make the determinations and hear appeals provided for in this act in a timely manner pursuant to regulations proposed by the commissioner and approved by the board. Such regulations shall be presented to the Standing Legislative Committees on Institutions, Health and Welfare for final approval within 1 year following establishment of the commission pursuant to the provisions of this act, and shall remain in effect in the form proposed by the commissioner and approved by the board until the provisions of such regulations are enacted into law as amendments to this act. Such regulations shall require that in the event the commission does not perform its duties within the time period specified therein the commission may permit a hospital to make a temporary reasonable change in rates which shall be effective immediately, when it deems it in the public interest to do so. Notwithstanding such temporary change in rates, the review procedure set forth in this section shall be conducted by the commission as soon thereafter as is possible.

b. Pursuant to regulations proposed by the commissioner and approved by the board, the commissioner shall propose and the

commission shall make automatic periodic adjustments to each preliminary cost base or certified revenue base for changes in economic factors reasonably calculated to provide for the effects of general economic inflation or deflation; for industry wide changes in the efficiency of delivering health care services; and for each hospital's actual changes in volume and case-mix, which are necessary and appropriate. The commission shall approve an appropriate change in the schedule of rates to reflect these adjustments.

c. Pursuant to regulations proposed by the commissioner and approved by the board, the commission shall consider adjustments to the certified revenue bases and schedules of rates, provided such adjustments: (1) result from statutes and regulations affecting the delivery of health care; and (2) may affect one or more hospitals. Such adjustments shall take into account the effectiveness and efficiency of the health care delivery system as a whole. Where appropriate the commission may sit en banc and hold public hearings in order to obtain the evidence required to support its conclusions and determinations. In the case of such hearings the commission shall provide actual notice to the affected planning and licensing authorities and hospitals, and to the commissioner and the Public Advocate.

d. Pursuant to regulations proposed by the commissioner and approved by the board, all other changes in the commission's determinations shall require a review by the commission in a public hearing of the entire preliminary cost base or certified revenue base and schedule of rates. Determinations of the commission may be appealed by hospitals, the commissioner, the Public Advocate, affected planning, licensing or inspection agencies and payors, and other affected parties, and shall be conducted as contested proceedings under the Administrative

Procedures Act, P.L. 1968, c. 410 (C. 52:14B-1 et seq.). During the pendency of any appeal, the schedule of rates approved by the commission pursuant to sections 5 and 10 of this act[1] shall remain in effect.

In all appeals, the burden of proof shall be on the petitioner. All determinations rendered hereunder shall be consistent with regulations and shall set forth in detail the commission's reasoning and conclusions regarding the parties and considerations specified in this act.

P.L. 1971, c. 136, § 18

* * *

18.

a. No government agency and no hospital service corporation organized under the laws of the State shall purchase, pay for or make reimbursement or grant-in-aid for any health care service provided by a health care facility unless at the time the service was provided, the health care facility possessed a valid license or was otherwise authorized to provide such service.

b. Payment by government agencies for health care services provided by a health care facility shall be at rates established by the commissioner, based on elements of costs approved by him.

c. The Commissioner of Health in consultation with the Commissioner of Insurance shall determine and certify the costs of providing health care services, as reported by health care facilities, which are derived in accordance with a uniform system of cost

1. Sections 26:2H-4.1, 26:2H-18.

accounting approved by the Commissioner of Health. Said certification shall specify the elements and details of costs taken into consideration.

d. Payment by hospital service corporations, organized under the laws of this State, for health care services provided by a health care facility shall be at rates approved as to reasonableness by the Commissioner of Insurance with the approval of the Commissioner of Health. In establishing such rates, the commissioners shall take into consideration the total costs of the health care facility.

P.L. 1991, c. 187, § 1

CHAPTER 187

1.[1] (New section) The Legislature finds and declares that:

a. Access to quality health care shall not be denied to residents of the State because of their inability to pay for the care; there are many residents of the State, particularly those with incomes below the federal poverty level, who cannot pay for needed hospital care and in order to ensure that these persons have equal access to hospital care it is necessary to maintain a mechanism which will ensure payment of uncompensated hospital care; and to protect the fiscal solvency of the State's general hospitals, as provided for in P.L. 1971, c. 136 (C. 26:2H-1 et al.), it is necessary that all payers of health care services share equally in the payment of uncompensated care on a Statewide basis.

b. The "New Jersey Uncompensated Care Trust Fund," created pursuant to P.L. 1986, c. 204, and continued pursuant to

1. N.J.S.A. 26:2H-18.24.

Appendix B

P.L. 1989, c. 1 (C. 26:2H-18.4 et seq.), which law expired on December 31, 1990, by which hospitals were able to collect their reasonable cost of approved uncompensated care, resulted in unobstructed access to health care for reidents without insurance who otherwise are unable to afford care.

c. Having received and thoroughly reviewed the reports issued by the Commissioner of Health and the Governor's Commission on Health Care Costs on uncompensated care, its economic implications and various means of financing uncompensated care, it is evident that provision for a trust fund is necessary, with modifications, to ensure access to hospital care for those who cannot afford to pay and the fiscal solvency of hospitals. At the same time, the State should take further actions to: provide more comprehensive Medicaid coverage for the medically indigent, reduce the rate of increase in health insurance premiums and explore and implement various initiatives to reduce the amount of uncompensated care in this State without impairing access to care.

Supreme Court, U.S.
FILED
SEP 29 1993
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Nos. 93-115, 93-193, 93-194, 93-210

In The

Supreme Court of the United States

October Term, 1993

NYSA-ILA WELFARE FUND, et al.,

Petitioners,

v.

FRANCES J. DUNSTON, in her capacity as NEW JERSEY COMMISSIONER OF HEALTH, et al.,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Third Circuit*

RESPONDENTS' BRIEF AND APPENDIX IN OPPOSITION TO PETITIONS FOR A WRIT OF CERTIORARI

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NEW JERSEY CARPENTERS WELFARE FUND, et al.,

Petitioners,

v.

FRANCES J. DUNSTON, in her capacity as
NEW JERSEY COMMISSIONER OF HEALTH, et al.,

Respondents.

TRUSTEES OF THE WELFARE TRUST FUND,
LOCAL UNION NO. 475, et al.,

Petitioners,

v.

FRANCES J. DUNSTON, in her capacity as
NEW JERSEY COMMISSIONER OF HEALTH, et al.,

Respondents.

UNITED WIRE, METAL & MACHINE HEALTH
AND WELFARE FUND, et al.,

Petitioners,

v.

MORRISTOWN MEMORIAL HOSPITAL, et al.,

Respondents.

QUESTIONS PRESENTED

1. Did New Jersey's now-repealed system of hospital rate regulation "relate to" employee benefit plans within the meaning of section 514(a) of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1144(a)? More generally stated, does a state regulatory system that sets the price of hospital care for patients but that does not impose any coverage or reimbursement obligations on third-party payors "relate to" employee benefit plans?

2. Does a state system of hospital rate regulation that folds into the rate structure costs arising from the provision of hospital care to non-paying or underpaying patients result in a compensable "taking" of employee benefit plan property?

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STATEMENT OF THE CASE

I. New Jersey's Former Rate System.

In 1978, the New Jersey Legislature enacted a system of hospital rate regulation to "promote the financial solvency of hospitals . . . and contain the rising costs of health care services." N.J. Stat. Ann. ("N.J.S.A.") 26:2H-1 (amended 1992).* Under this system, the many types of medical procedures performed at hospitals were divided into "diagnostic related groups" ("DRGs"), and a rate assigned to each DRG. The system was designed to penalize hospitals that incurred costs greater than the DRG rate and to reward more efficient hospitals, thereby providing hospitals with an incentive to keep costs down. *See, e.g.*, N.J. Admin. Code ("N.J.A.C.") 8:31B-3.5.

Like most if not all regulatory rate systems, New Jersey's former hospital rate system operated on the premise that the rates should allow efficient members of the regulated industry to recover their reasonable costs of doing business. N.J.A.C. 8:31B-1.1. One cost of doing business as a hospital is the cost of providing care to patients who are unable to pay their bills, a cost known as "uncompensated care." In all states, hospitals incur substantial uncompensated care costs, both because federal law requires hospitals to treat emergency patients regardless of ability to pay, *see* 42 U.S.C. § 1395dd, and because many hospitals, under their internal by-laws and operating procedures, impose similar requirements on themselves. In New Jersey, state law requires all hospitals to

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*The New Jersey Statutes referenced herein are reproduced in the Appendix to the Brief in Opposition on behalf of respondent New Jersey Hospital Association.

accept and treat patients regardless of ability to pay. *See* N.J.S.A. 26:2H-18.64; N.J.A.C. 8:43G-5.2(c).

Under the rate system as originally enacted, uncompensated care costs incurred by a particular hospital were borne only by that hospital's patients. Each hospital, therefore, included in its rates a hospital-specific charge for uncompensated care in order to recover its costs in this area. Over time, hospitals providing large amounts of uncompensated care – primarily hospitals located in the state's urban areas – were thus forced to charge higher rates than other hospitals. The resultant disparity in rates threatened the financial viability of New Jersey's inner-city hospitals.

In response to this problem, and to avoid the prospect of large urban areas and populations with no accessible hospital care, New Jersey amended its rate-setting system in 1987 to provide that all hospitals in the state would share equally in the cost of uncompensated care. Under this amendment, all hospital bills were required to include a uniform uncompensated care charge, set annually by the State's Hospital Rate-Setting Commission at a level intended to generate revenues approximating statewide uncompensated care costs. N.J.S.A. 26:2H-18(d) (repealed 1992). The charges collected from all patients and hospitals across the state were then pooled into a fund known as the New Jersey Health Care Trust Fund, and ultimately redistributed back to hospitals according to the amount of uncompensated care provided by them.

Another cost of doing business as a hospital (in some respects a variant of uncompensated care) is the cost of treating patients eligible for Medicare. Under federal law,

hospitals can charge such patients only the amount Medicare pays for the particular treatment. From 1980-1988, the Medicare program participated fully in New Jersey's rate system and accepted the rates established by it. In 1989, however, Medicare began paying hospitals in New Jersey at rates below the state-regulated rate – and, as has been widely acknowledged, below any reasonable measure of the cost of providing care. To enable hospitals to make up for the resultant shortfall in revenues, the state-regulated rate had to be adjusted, and a charge included in all hospital bills to make up for Medicare's below-cost reimbursement rates. *See* N.J.S.A. 26:2H-18(c) (repealed 1992). This charge came to be known, in New Jersey as elsewhere, as the "Medicare cost-shift." *See generally,* Congressional Report C-92-03, "Optional Hospital Payment Rates for Private Payers Based on Medicare's Methods" (March 1992) (detailing the prevalence throughout the United States of Medicare cost-shifts by hospitals).

Another charge built into hospital rates under New Jersey's former rate system related to "payor differentials." Under the operative rate statutes, and in keeping with their underlying purpose of cost-containment, the Hospital Rate Setting Commission was authorized to grant a "differential" (*i.e.*, price discount) to payors providing "quantifiable economic benefits . . . to the health care delivery system taken as a whole." *See* N.J.S.A. 26:2H-18(b) (repealed 1992). Under this provision, differentials were provided to "open enrollment" programs such as Blue Cross/Blue Shield because, by offering open enrollment, such programs reduced (or at least helped to contain) the number of uninsured patients – and, hence,

to contain the uncompensated care costs incurred by hospitals. Blue Cross receives a similar discount in many states. *See generally,* P. Ginsburg, "Hospital Cost Shifting," 310 New England Journal of Medicine 893 (April 1984). Payor differentials were also granted to health maintenance organizations ("HMOs") able to show the achievement of economic benefits through their efforts at "managed care." Hospital patients covered by Blue Cross or HMOs would thus be charged at a discounted rate, and patients not covered by such plans would be charged at a correspondingly higher rate.

New Jersey's former rate system did not dictate that third-party payors cover or be responsible for paying any amount, percentage or portion of hospital bills. Rather, it set the price of hospital care *for patients* in New Jersey. Third-party payors like the petitioning employee benefit plans were, as both a legal and practical matter, free to determine for themselves how much coverage they would provide for their plan members.*

Under the rate system, hospital costs in New Jersey rose steadily, as they did throughout the country during that time period (1978-1993). Data compiled by the American Hospital Association showed, however, that hospital rates in New Jersey during the period of rate regulation were generally lower than in neighboring states. From the

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*This feature of New Jersey's former rate system distinguishes it from the statutory scheme at issue in *Bricklayers Local No. 1 Welfare Fund v. Louisiana Health Ins. Ass'n,* 771 F. Supp. 771 (E.D.La. 1991), which involved charges imposed directly on ERISA plans, and from other cases that have occasionally arisen under ERISA involving state "mandatory benefits" laws.

record in this case, it cannot be said whether the rate system held the cost of hospital care below what it would have been in the absence of regulation, raised it above what it would otherwise have been, or had no substantial impact at all. Petitioners' repeated assertions that the rate system had a net detrimental economic impact on them is unsubstantiated. *See* Sup.Ct.R. 15.1.

II. The Proceedings Below.

In 1990, despite the fact that hospital rates in New Jersey were then generally lower than rates in nearby states, a number of self-insured employee benefit plans ("the Plans") filed suit in the United States District Court for the District of New Jersey, asserting that the State's rate system was preempted by ERISA. The Plans also asserted that the rate system resulted in a taking of their property without just compensation, and constituted an unlawful tax.

With respect to their preemption claim, the Plans contended that, because rates promulgated under the regulatory scheme included charges for uncompensated care, the Medicare cost-shift and payor differentials, plan administrators were effectively being compelled to divert plan resources to the benefit of non-beneficiaries, in direct violation of their fiduciary obligations under ERISA. In response, the State asserted that the challenged charges represented bona fide components of a regulated rate and thus did not constitute a diversion of plan assets, and that the rate system did not "relate to" ERISA plans but rather set the price of hospital care for patients.

In the District Court, all parties moved for summary judgment, and on May 27, 1992, the court (Hon. Alfred Wolin, U.S.D.J.) issued a decision holding in the Plans' favor on their preemption claim. In its decision, the District Court found that New Jersey's rate system related to employee benefit plans because it forced them "to structure benefits in a particular manner and subject[ed] the benefit plans to inconsistent regulations" from one state to another (80a).* The court rejected the Plans' constitutional arguments (85a).

The District Court thereafter entered an order enjoining the State and hospitals in the state from enforcing the contested rate statutes against the Plans. Surprisingly, the District Court also enjoined enforcement of the rate statutes against plan *beneficiaries*, because in the District Court's expansive view ERISA not only precluded the State from imposing the disputed charges against employee benefit *plans* (the rate system imposed no such charge), but also precluded it from imposing the charges against patients who happened to be enrolled in such plans (the rate system did impose such a charge, against *all* patients) (*See*, Appendix to this Brief).

On June 24, 1992, before the District Court's order took effect, the United States Court of Appeals for the

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*The District Court was unable to support this holding with a citation to any provision of state law requiring employee benefit plans to structure their benefits in any specified manner. Petitioners are likewise unable to do so anywhere in the four petitions they have filed. No such provision exists. (Appendix citations are to the appendix filed by petitioner NYSA-ILA Welfare Fund.)

Third Circuit issued a stay pending appeal. On appeal, in an opinion dated May 14, 1993, the Third Circuit reversed. The Third Circuit rejected the District Court's unsupported conclusion that New Jersey's rate system "force[d] employee benefit plans to structure benefits in a particular manner" (80a), and noted that, to the contrary, "New Jersey's scheme does not direct ERISA plans to structure their benefits or conduct their internal affairs in any particular way." (26a-27a). The Court of Appeals acknowledged that the rate system, by setting the price of hospital care in New Jersey, had an economic impact on employee benefit plans, but concluded that such an impact did not necessitate or justify a finding of preemption under the applicable decisions of this Court (26a).

With respect to the plans' contention that the rate system compelled them to divert plan assets to non-beneficiaries, the Third Circuit noted that this argument, if accepted, would give rise to a duty on the part of plan administrators to " 'look through' the pricing structure of every health care provider to assure that the price of the services rendered a particular patient directly correlates with the cost of those services." (31a). Such a duty, the court continued, would prove a practical impossibility in view of the "many forms of state regulation . . . which result in increases in the cost of [hospitals'] doing business." (31a). The court therefore concluded that Congress did not intend to impose such a duty on plan administrators, just as it never intended, through ERISA, to preempt states from exercising their traditional far-reaching regulatory powers over hospitals (32a).

Summarizing its preemption holding, the court concluded that New Jersey's former rate system was a

> generally applicable law which (1) is not intended to regulate the affairs of ERISA plans, (2) neither singles out such plans for special treatment nor predicates rights or obligations on the existence of an ERISA plan, and (3) does not have the effect of either dictating or restricting the manner in which ERISA plans structure or conduct their affairs or the effect of impairing their ability to operate simultaneously in more than one state. We have found no case that has held such a law to be preempted . . . and we decline to so hold. [30a].

The Third Circuit also rejected the Plans' "takings" arguments (22a). Applying the standards of *Penn Central Transportation Co. v. City of New York*, 438 U.S. 104 (1978), the court found that the rate system did not interfere with the plans' investment-backed expectations, but merely adjusted "the benefits and burdens of economic life to promote the common good." *Connolly v. Pension Benefit Guaranty Corp.*, 475 U.S. 211, 225 (1986).

In dissent, Judge Nygaard wrote that the case "tests the outer limits of ERISA preemption" (32a), but that he would affirm the District Court's judgment. Judge Nygaard was persuaded that a preemptive "relation" between the rate system and ERISA plans existed because the rate system, as all parties acknowledged, would not be viable if ERISA plans and their beneficiaries were excluded from it.

III. New Jersey's Deregulation of Hospital Rates.

During the time that this matter was before the Third Circuit, New Jersey abolished its hospital rate system,

which had been politically controversial from its outset, and deregulated hospital rates. 1992 N.J. Laws, c.160. In an attempt to avoid the price volatility and disruptions that might otherwise arise with deregulation, the Legislature imposed one-year revenue caps on all hospitals, but as of January 1, 1993, the rate system that is the subject of this case ceased to exist.

Although this development rendered the Plans' claims for prospective relief moot, it did not render moot their attempt to avoid responsibility for paying hospital bills issued to their plan members during the pendency of the action – a responsibility, it bears repeating, imposed upon them by their own governing plan instruments, not by the rate system. The Third Circuit accordingly proceeded to decide the appeal before it (22a).

REASONS FOR DENYING THE WRIT

I. Summary of Argument.

In urging the Court to grant certiorari, petitioners assert that the opinion below conflicts with applicable ERISA decisions of this Court and other circuits. This assertion does not withstand scrutiny. The opinion below adheres to settled principles of preemption law, reaches a result that accords with this Court's ERISA decisions, and expressly follows the one other Court of Appeals decision to address a similar issue, *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985) (upholding New York's hospital rate system against an ERISA challenge).

Petitioners correctly maintain that this Court, in its recent ERISA decisions, has reaffirmed that ERISA's preemptive scope is broad, *see, e.g., FMC Corp. v. Holliday,* 498 U.S. 52, 58 (1990), but this uncontroversial point was not lost on the court below. The Court of Appeals recognized that the legal inquiry did not end there, however, since it remains true under recent decisions that ERISA's preemptive reach, though broad, is not without limits, and that state laws of general applicability having only a tenuous, remote or peripheral connection with employee benefit plans are not preempted. *District of Columbia v. Greater Washington Board of Trade,* 113 S.Ct. 580, 583 (1992); *Ingersoll-Rand Co. v. McClendon,* 498 U.S. 33, 39 (1990).

Although petitioners cast themselves as defenders of this Court's ERISA jurisprudence, the result they seek to achieve is far outside the domain of established law. Petitioners' central thesis – which they understandably choose not to state in express terms – is that ERISA precludes states from engaging in hospital rate regulation. Thus, at the same time that petitioners assert that ERISA provides a federal exemption from New Jersey's rate system for their plan beneficiaries, they also acknowledge, and even stress, that any hospital rate system that excluded patients covered by employee benefit plans from its scope would, as a practical matter, be unworkable. *See, e.g.,* Petition of United Wire, Metal & Machine Health and Welfare Fund at 21-22.

As is clear on a moment's reflection, if the latter point is true (and it quite clearly is), it follows that ERISA effectively prohibits states from engaging in hospital rate regulation. *Cf. Travelers Inc. Co. v. Cuomo,* 813 F.Supp. 996,

1006 (S.D.N.Y. 1993) *appeal pending* (holding New York's hospital rate system to be preempted; the court acknowledged that, under its legal analysis, it would follow that "ERISA preempts all state hospital rate-setting statutes.") From a public policy standpoint, such a result might or might not be beneficial (the data from New Jersey are inconclusive), but from a legal standpoint there is no reason to think that Congress intended to achieve that result when it enacted ERISA. To the contrary, Congress has consistently encouraged state efforts to contain health care costs. *See, e.g.*, 42 U.S.C. § 1395ww(6)(1) (authorizing the Secretary of Health and Human Services to waive Medicare's rate schedule and to participate in state "hospital reimbursement control systems").

Petitioners' underlying thesis is not only at odds with Congressional intent, but rests on a legal paradox. Under clearly established law, any state system of hospital rate regulation that purported to *exclude* employee benefit plans and their beneficiaries from its scope would be flatly preempted. *Mackey v. Lanier Collection Agency & Services, Inc.*, 486 U.S. 825 (1988) (Georgia garnishment statute providing exemption for employee benefit plans "related to" such plans and was preempted). If petitioners' position were upheld, therefore, ERISA would prevent states from including *or* excluding plan beneficiaries from a rate-setting system – which is again to say that states could not engage in rate regulation at all.

The Court of Appeals did not depart from established law in rejecting petitioners' boundless interpretation of ERISA. The decision below comports with the applicable precedents of this Court, presents no conflict with any other circuit court decision, and is sound on its

own merits. With the repeal of the rate system, any arguable "special and important reasons" that might once have existed to warrant this Court's involvement have vanished, Sup.Ct.R. 10, and the petitions for certiorari should accordingly be denied.

II. The Decision Below Represents a Correct Application of Settled ERISA Law and Is Not in Conflict With the Law of Any Other Circuit.

A. ERISA Preemption Standards.

ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). In determining whether a state law "relates to" employee benefit plans under the statute, "as in any preemption analysis 'the purpose of Congress is the ultimate touchstone.' " *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747 (1985) (quoting *Malone v. White Motor Corp.*, 435 U.S. 497, 504 (1978)).

Congress' purpose in enacting ERISA was "to safeguard employees from the abuse and mismanagement of [employee benefit] funds." *Massachusetts v. Morash*, 490 U.S. 107, 112 (1989). To effectuate this purpose, ERISA imposes uniform federal standards on reporting, disclosure and fiduciary responsibility, 29 U.S.C. §§ 1021-1031, 1101-14, but a state law need not intrude upon these specific subject areas to be preempted, nor need its relation to employee benefit plans be direct or express. *FMC Corp. v. Holliday*, 498 U.S. 52, 58-59 (1990). Rather, a state law "relates to" employee benefit plans if, within the "broad common-sense meaning of that

phrase," it "has a connection with or reference to" such plans. *Ingersoll-Rand, supra,* 498 U.S. at 39; *see also Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41, 47 (1987).

On the other hand, a state law that has only a "tenuous, remote or peripheral connection with covered plans . . . as is the case with many laws of general applicability" will not be preempted. *District of Columbia v. Greater Washington Board of Trade,* 113 S.Ct. 580, 583 n.1 (1992); *Ingersoll-Rand, supra,* 498 U.S. at 39 (generally applicable statutes that make no reference to or function irrespective of benefit plans not preempted). Preemption follows only if a state law relates to employee benefit *plans,* moreover. *Fort Halifax Packing Company, Inc. v. Coyne,* 482 U.S. 1, 8 (1987) ("Congress' choice of language is significant" in that it preempts only laws that relate to plans); *Ingersoll-Rand, supra,* 480 U.S. at 39 ("only state laws that relate to benefit plans are preempted"); *cf. Alessi v. Raybestos-Manhattan, Inc.,* 451 U.S. 504, 523 (1981) (Congress, in enacting ERISA, "meant to establish pension plan regulation as exclusively a federal concern").

B. Discussion.

The decision below represents a straightforward application of these settled legal standards. The Court of Appeals examined each asserted connection between the Plans and the rate statutes, and rightly concluded that, under the ERISA decisions of this Court, none of them established the requisite preemptive "relation." In so holding, the court was guided not only by the decisions of this Court (24a-26a), but also by the one other Court of Appeals decision to address an ERISA challenge to a

state system of hospital rate regulation, *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985).

As they did below, petitioners vigorously assert that *Rebaldo* is no longer good law because it pre-dates this Court's decisions in *FMC Corp.* and *Ingersoll-Rand Co.*, and because certain passages from the Second Circuit's opinion take a narrower view of ERISA's preemptive scope than the Court espoused in those later cases. The court below, however, was careful to limit its reliance on *Rebaldo* to those portions of the opinion that remain legally sound. In particular, the court below embraced the observation made in *Rebaldo* that a finding of preemption cannot be based on the mere fact that a state statute or regulation affects a plan's "cost of doing business" since many (if not all) types of state regulations have such an effect. 749 F.2d at 138-39. In making that observation, the Second Circuit was not announcing a new or controversial rule of law; it was stating a plain fact, and nothing in the ERISA cases that have been decided since *Rebaldo* erodes the Second Circuit's wholly logical reasoning on this score. *Accord Lane v. Goren*, 743 F.2d 1337, 1340 (9th Cir. 1984) (state statutes prohibiting employment discrimination not preempted despite the fact that such laws, like laws "regulating zoning, health and safety, increase the operational costs of ERISA trusts").

Another intrinsically sound aspect of the *Rebaldo* opinion is its recognition that whether or not states engage in rate regulation, hospitalization costs will always vary from state to state and that, in consequence, statutes that merely set the price of hospital care within a given state cannot be said to subject ERISA plans to

inconsistent local regulation. 749 F.2d at 139. Petitioners are unable to point to any flaw in this syllogism, but assert that New Jersey's rate statutes did more than set the price of hospital care because it imposed a "disproportionate" share of certain costs on ERISA plans. Thus, petitioners inveigh that, in the last years of the rate system, ERISA plan participants constituted only 15% of New Jersey's hospital patients but were assessed with 40% of the challenged "cost shifts."

Although plausible on its face, petitioners' "disproportionality" argument turns out, on examination, to be an exercise in statistical sophistry. The seeming inequity of the distribution of the costs shifts evaporates when it is recalled that the largest of the "cost shifts" – by far – related to uncompensated care, *i.e.*, care rendered to nonpaying or underpaying patients. By definition, such patients (who unfortunately constitute a substantial portion of the total patient population themselves) will not bear their "proportional" share of costs; rather they will *cause* hospitals to have to seek to recover those costs from all other patients, thus *creating* a "disproportionate" load for those patients.

To the extent petitioners' "disproportionality" argument does more than reflect the fact that hospitals in New Jersey, as in other states, incur substantial uncompensated care costs, it is still lacking in force. The "cost shift" that arose from Medicare's below-market reimbursement rates was as much a product of federal law as it was of New Jersey's rate system, and petitioners provide no support for the notion that Congress intended ERISA plan participants, alone among non-Medicare patients, to be exempted from such costs. Likewise, the challenged

"cost shift" relating to payor differentials resulted in no true "disproportion," since such differentials were granted only on the basis of demonstrated economies benefiting the hospital system as a whole. Nothing in the record suggests any gross disparity between the size of the payor differentials and the benefits bestowed.

Petitioners' aspersive descriptions of the challenged "cost shifts" notwithstanding, *see, e.g.*, NYSA-ILA Petition at 7-8,* each of the charges in question corresponded to a real cost of doing business as a hospital, and consequently each of the charges was a legitimate component of a regulated hospital rate. That being so, petitioners' preemption argument amounts to a claim that, through ERISA, Congress has given plan administrators unilateral power (or, as the Court of Appeals put it, a duty) to determine for themselves and their plan beneficiaries what constitutes a "reasonable" hospital bill. Unpersuasive as this contention is on first blush, it becomes even less attractive when one considers that, were it to be upheld, federal courts would become the arbiters of everyday billing disputes between ERISA plan members and healthcare practitioners, and would have to develop

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*Petitioners' oft-repeated assertion that New Jersey's rate system was deliberately designed to target ERISA funds and to discriminate against employee benefit plans is more than aspersive; it is false. *See* Sup.Ct.R. 15.1. Since the rate system imposed no coverage obligations on ERISA plans (or any other third-party payors), it was fundamentally incapable of "discriminating" against them in the fashion complained of; perhaps more to the point, petitioners are unable to show any respect in which ERISA plans or their beneficiaries were treated less favorably than ordinary commercial insurers and their beneficiaries.

a new body of federal common law to resolve such disputes.*

While the powers bestowed upon plan administrators under ERISA are broad, they convey no license to "mark down" hospital bills on behalf of plan members. *Rebaldo, supra,* 749 F.2d at 138-139 (rejecting the idea that ERISA plans lead a "charmed existence"). They *do* encompass a power to structure plan benefits to cover so much – or so little – of members' hospital bills as may be deemed desirable, but New Jersey's former rate statutes did not trammel upon or in any way limit that power. *Compare Metropolitan Life Ins. Co. v. Massachusetts,* 471 U.S. 724, 739 (1985) (mandatory benefits law "related to" employee benefit plans, but was not preempted as to insurance companies selling policies to plans); *FMC Corp. v. Holliday, supra* (anti-subrogation law preempted because it dictated how plans had to structure benefits.)

Petitioners' assertion that New Jersey's former rate statutes made express "reference" to employee benefit plans is even less compelling than their exaggerated claims of "discrimination." The *only* reference to ERISA plans in the rate statutes was contained in a provision imposing a duty on hospitals to ascertain whether a prospective patient had any form of medical coverage.

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*This would be true, it should be noted, even in states where hospital rates are not subject to state regulation. Throughout the country, the right of hospitals and doctors to collect on their bills is governed by state law, and whether that law derives from a statute or case law it "relates" to ERISA plans in exactly the same fashion and to the same extent as New Jersey's former rate laws – which is to say indirectly and peripherally.

N.J.S.A. 26:2H-18.31 (expired 1992). That provision required hospitals to

> inquire of the patient . . . whether the patient is covered by health insurance, and if so shall require documentation . . . Documentation may include a government sponsored health plan card or number, a group sponsored or direct subscription health plan card or number, a commercial identification card or claim form or a *union welfare plan identification card or claim form.* [Emphasis added.]

The obvious, and salutary, purpose of this provision was to ensure that hospitals took reasonable steps to keep their uncompensated care costs to a minimum. For petitioners, who complain so loudly about the growth of uncompensated care costs, to suggest simultaneously that the above provision ran afoul of ERISA is, to say the least, perplexing. Petitioners surely do not maintain that hospitals are prohibited by ERISA from ascertaining whether patients have some form of medical coverage, and yet they seem to be saying that hospital officials should be required to preface patient interviews with a warning to the effect of, "Under no circumstances should you tell me if you belong to a union benefit plan." Since such a disclaimer would *still* involve a "reference" to ERISA plans (at least as petitioners construe that term), the Court of Appeals did well to reject this odd contention, and broke no new legal ground in doing so. *See Pilot Life*

Ins. Co. v. Dedeaux, supra, 481 U.S. at 47 (ERISA's preemptive language should be given "its broad *common-sense* meaning"; emphasis added).*

In the final analysis, the only true "relation" between employee benefit plans and the challenged rate system is that, by setting the price of hospital care in New Jersey, the rate system had an undeniable, albeit indeterminate, economic impact on employee benefit plans. No decision by this Court has held that such an impact alone results in preemption. Petitioners assert that the Fifth Circuit has found economic impact to be sufficient to establish a preemptive "relation" in *E-Systems, Inc. v. Pogue,* 929 F.2d 1100 (5th Cir.), *cert. denied,* 116 L.Ed.2d 610 (1991), but that case involved a tax imposed specifically on persons rendering services to any "employer-employee . . . health benefit plan." Thus, the statute's relation to benefit plans was not merely economic, and was anything but "tenuous" and "peripheral"; to the contrary, it was direct and practically *exclusive.*

Petitioners also seize upon dicta from *Arkansas Blue Cross and Blue Shield v. St. Mary's Hospital, Inc.,* 947 F.2d 1341 (8th Cir. 1991), *cert. denied,* 112 S.Ct. 2305 (1992), in

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*The "reference" to employee benefit plans contained in the New Jersey Department of Health's policy statement regarding patient appeals again merely lists employee benefit plans as one possible form of third-party coverage. The policy statement (which was not itself part of the statutory rate scheme) merely recognized, as an incontrovertible fact, that employee benefit plans are a common type of third-party payor. That petitioners construe ERISA's preemptive language to mean that this fact must never be acknowledged in writing by state officials demonstrates the artificiality of their position.

an attempt to generate a conflict between the Eighth Circuit and the court below. In that case, the Eighth Circuit questioned – as the Fifth Circuit had done before it, *see Somers-Drug Stores v. Corrigan Enterprises Inc.*, 793 F.2d 1456, 1467 (5th Cir. 1986) – whether the fact that a state law falls within the state's traditional police powers has any legal relevance in ERISA preemption disputes. 947 F.2d at 1350. The court left the question hanging, although it allowed that "this factor is arguably a policy consideration useful in deciding borderline" ERISA cases. *Id.*

If the Fifth Circuit or Eighth Circuit ever chose to formalize their speculative views on this rather fine point of ERISA law in a legal holding, a genuine conflict among the circuits would clearly exist. *Compare, e.g., Aetna Ins. Co. v. Borges*, 869 F.2d 142, 144 (2d Cir.), *cert. denied*, 493 U.S. 811 (1989) (observing, in an ERISA case, "we must assume 'that the historic police powers of the State were not to be superseded . . . unless that was the clear and manifest purpose of Congress' "; quoting *Ray v. Atlantic Richfield Co.*, 435 U.S. 988, 994 (1978)). It seems doubtful that a genuine conflict on this point will ever arise, however, since this Court has made perfectly clear that, in addressing questions of preemption under ERISA – as under any other federal statute – the Court "must presume that Congress did not intend to preempt areas of traditional State regulation." *Metropolitan Life Ins. Co. v. Massachusetts, supra*, 471 U.S. at 740 (1985). This negative presumption is bottomed on basic precepts of federal-state comity; thus, for instance, in *Fort Halifax Packing Co. v. Coyne, supra*, the Court wrote:

> ERISA pre-emption analysis 'must be guided by respect for the separate spheres of governmental authority preserved in our federalist system.' [482 U.S. at 19, *quoting Alessi v. Raybestos-Manhattan, Inc,* 451 U.S. 504, 522 (1982)].

It is true, as the Eighth Circuit observed in *Arkansas Blue Cross, supra,* that the Court has not invoked this canon of statutory construction in its most recent ERISA decisions. Given the extensive body of ERISA law on which the Court is now writing, there would seem little need. Neither the Third Circuit nor any other Court of Appeals would be at liberty to assume that, by the omission, the Court has implicitly overruled its earlier decisions, *Rodriguez DeQuijas v. Shearson/American Express, Inc.,* 490 U.S. 477, 484 (1989), and no reason exists to think that it has.

The applicable decisions of this Court and of other circuits establish that where, as here, a regulatory scheme has an indirect economic impact on ERISA plans, a number of considerations must be taken into account to determine if the scheme is preempted. Those considerations include whether the law in question involves an exercise of traditional state police powers, *Metropolitan Life, supra,* as well as whether it interferes with the administration of ERISA plans, or mandates that they provide a particular type or level of benefit, or subjects them to inconsistent regulation. *See, e.g., Aetna Life Ins. Co. v. Borges, supra,* 869 F.2d at 145-146 (surveying ERISA cases and noting that Congress "could not possibly have meant to preempt all laws having any impact on plans, no matter how small or how tangential"). The Court of Appeals examined each of these relevant criteria, and

concluded that they did not support a finding of preemption. The court's legal analysis and conclusion were consistent with and faithful to existing law, and its rejection of petitioners' overreaching contention that ERISA precludes state regulation of hospital rates presents no reason for further review by this Court.

III. The Court of Appeals' Holding That New Jersey's Hospital Rate-setting System Does Not Result in a Compensable "Taking" of the Plans' Property Presents No Questions Requiring Review by This Court.

The NYSA-ILA Plan, alone among petitioners, seeks review of the Court of Appeals' affirmance of the District Court's dismissal of the Plans' "takings" claim. The Court of Appeals' decision on this point represents a sound and even elementary application of established law, and does not remotely meet any of the criteria for issuance of a writ of certiorari.

Outside the area of "physical" takings, a three-prong test determines whether a compensable taking has occurred. Under that test, courts must examine the character of the governmental action involved, the economic impact of that action on the claimant, and the extent to which it has interfered with the claimant's "distinct investment-backed expectations." *Penn Central Transportation Co. v. City of New York*, 438 U.S. 104, 124 (1978).

The challenged governmental action here is the inclusion of certain "indirect" costs in regulated hospital rates. The costs in question, while indirect, are true costs incurred by hospitals and, in providing for them to be

spread among all hospitals and hospital patients, New Jersey's rate system sought merely to adjust "the benefits and burdens of economic life to promote the common good." *Connolly v. Pension Benefit Guaranty Corp.*, 475 U.S. 211, 223 (1986). The economic impact of New Jersey's rate system upon the Plans, as has been noted, is indeterminate since hospital rates in New Jersey under the system were roughly in line with, but somewhat lower than, rates in nearby states. Clearly, though, the system did not interfere with the Plans' "investment-backed expectations." The Plans exist in order to pay the medical bills of their beneficiaries, and have never had a reason to think that their beneficiaries occupy a special status among hospital patients exempting them from charges borne by other patients. The Court of Appeals' rejection of Petitioners' unmeritorious takings argument thus needs no attention from this Court.

CONCLUSION

For the foregoing reasons, the petitions for writ of certiorari should be denied.

Respectfully submitted,

FRED DEVESA
Acting Attorney General of
New Jersey

BENJAMIN CLARKE
Assistant Attorney General

Dated: September 29, 1993

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

UNITED WIRE, METAL & MACHINE HEALTH AND WELFARE FUND, et al.,	Civil Action No. 90-2639 (Consolidated)
Plaintiffs,	AMENDED ORDER
v.	(Filed June 4, 1992)
MORRISTOWN MEMORIAL HOSPITAL, et al.,	
Defendants.	

The Court hereby amends its Order dated May 27, 1992 as follows:

It is on this 4th day of June, 1992,

ORDERED, that the state defendants are permanently enjoined from enforcing the provisions stated in its May 27, 1992 order as to participants in ERISA plans only.

/s/ Alfred M. Wolin
ALFRED M. WOLIN, U.S.D.J.

No. 93-115

IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

NYSA-ILA WELFARE FUND, by its Trustees, JOHN BOWERS, ALBERT CERNADAS, FRANK LONARDO, THOMAS POPOLA, JAMES CAPO, JOSEPH N. BARBERA, BART DiMATTINA, and RICHARD H. O'NEILL,

Petitioner,

v.

FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; AND COLUMBUS HOSPITAL, EAST ORANGE GENERAL HOSPITAL, ST. JAMES HOSPITAL, and UNIVERSITY HOSPITAL, individually and as Class Representatives of Hospitals in the State of New Jersey; and NEW JERSEY HOSPITAL ASSOCIATION, as Class Representative of Hospitals in the State of New Jersey,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

SUPPLEMENT TO PETITION

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TABLE OF AUTHORITIES

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Cases:

Rebaldo v. Cuomo, 749 F.2d 113 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985) . . *passim*

Travelers Ins. Co. v. Cuomo, No. 93-7132L (2d Cir. Oct. 25, 1993), *aff'g* 813 F. Supp. 996 (S.D.N.Y. 1993) . . . . . *passim*

Rules:

Sup. Ct. R. 15.7 1

No. 93-115

IN THE
SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1993

NYSA-ILA WELFARE FUND by its Trustees, JOHN BOWERS, ALBERT CERNADAS, FRANK LONARDO, THOMAS POPOLA, JAMES CAPO, JOSEPH N. BARBERA, BART DiMATTINA, and RICHARD H. O'NEILL,

Petitioner,

v.

FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; AND COLUMBUS HOSPITAL, EAST ORANGE GENERAL HOSPITAL, ST. JAMES HOSPITAL, and UNIVERSITY HOSPITAL, individually and as Class Representatives of Hospitals in the State of New Jersey; and NEW JERSEY HOSPITAL ASSOCIATION, as Class Representative of Hospitals in the State of New Jersey,

Respondents.

On Petition For A Writ Of Certiorari To The
United States Court Of Appeals For The Third Circuit

SUPPLEMENT TO PETITION

This supplement is filed, pursuant to Sup. Ct. R. 15.7, to bring to this Court's attention the recent decision of the United

States Court of Appeals for the Second Circuit in *Travelers Ins. Co. v. Cuomo*, No. 93-7132L (2d Cir. Oct. 25, 1993). The Second Circuit's decision, which is reproduced as an appendix to this supplement, is in conflict with the Third Circuit's decision that is the subject of the petition for certiorari in this case.

The opinion of the Second Circuit is intimately related to the case now before this Court. It involves the identical issue of ERISA pre-emption of New York's hospital rate-setting reimbursement system, which is similar to the New Jersey system at issue in this case. Indeed, the surcharges challenged in *Travelers* are substantively identical in purpose and effect to the payor discounts involved in this case. In a 39-page unanimous opinion, the Second Circuit reviewed (1) the factual background surrounding the formulation and enactment of the surcharges in the New York hospital reimbursement legislation, (2) the fundamental legal principles embodied in the doctrine of ERISA pre-emption, and (3) the fundamental defect in the Second Circuit's earlier decision in *Rebaldo v. Cuomo*, 749 F.2d 113 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985), upon which the Third Circuit so heavily relied. The Second Circuit then concluded that the surcharges mandated by the New York legislation are pre-empted by ERISA because in light of their significant economic burden and impermissible impact on ERISA plans they have a connection with and, hence, relate to ERISA plans, so as to trigger pre-emption.

The Second Circuit's resolution of the ERISA pre-emption issue directly and irreconcilably conflicts with the decision of the Third Circuit in this case. The Second Circuit expressly acknowledges the conflict and in no uncertain terms declines to follow the Third Circuit's determination. *See Travelers*, slip op. at 23a n.2. Indeed, the Second Circuit faults the Third Circuit

in two respects. First, it discredits the Third Circuit's reliance on *Rebaldo*, the earlier Second Circuit decision which in the *Travelers* court's view rests on a premise that has been significantly eroded by later decisions of this Court. *Id.* at 23a n.2. Second, the Second Circuit criticizes the Third Circuit for reading ERISA's pre-emption clause too narrowly. *Id.* at 23a n.2.

Certainly the views expressed by the Second Circuit in *Travelers* are in irreconcilable conflict with the Third Circuit's decision in this case. *Travelers* highlights the national importance of the ERISA pre-emption issue and the sharp inter-circuit judicial discord that has arisen. It underscores the need for this Court's review of the exceptionally important issue presented in this case. The petition for a writ of certiorari should be granted.

Dated: New York, New York
October 26, 1993

Respectfully submitted,

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APPENDIX

UNITED STATES COURT OF APPEALS

FOR THE SECOND CIRCUIT

Nos. 1514, 1515, 1516, 1667—August Term, 1992

(Argued: May 20, 1993 Decided: October 25, 1993)

Docket Nos. 93-7132L, 93-7134CON,
93-7148CON, 93-7194XAP

THE TRAVELERS INSURANCE COMPANY,

Plaintiff-Appellee-Cross-Appellant,

HEALTH INSURANCE ASSOCIATION OF AMERICA, AMERICAN COUNCIL OF LIFE INSURANCE, LIFE INSURANCE COUNCIL OF NEW YORK, INC., AETNA LIFE INSURANCE CO., AETNA HEALTH PLANS OF NEW YORK, INC., MUTUAL OF OMAHA INSURANCE COMPANY, THE UNION LABOR LIFE INSURANCE COMPANY, PROFESSIONAL INSURANCE AGENTS OF NEW YORK, INC. TRUST,

Plaintiffs-Appellees,

NEW YORK STATE HEALTH MAINTENANCE ORGANIZATION CONFERENCE AND HEALTH SERVICES MEDICAL CORPORATION, MVP HEALTH PLAN, WELLCARE OF NEW YORK, MID-HUDSON HEALTH PLAN, OXFORD HEALTH PLAN, CAPITAL DISTRICT PHYSICIANS HEALTH PLAN, CHOICECARE LONG ISLAND, INDEPENDENT HEALTH, TRAVELERS

OF NEW YORK, PHYSICIANS HEALTH SERVICES, PREFERRED CARE and U.S. HEALTHCARE,

Plaintiffs-Intervenors-Appellees,

--v.—

MARIO M. CUOMO, in his official capacity as Governor of the State of New York, MARK CHASSIN, M.D., in his official capacity as Commissioner of Health for the State of New York, SALVATORE R. CURIALE, in his official capacity as Superintendent of Insurance of the State of New York, MARY JO BANE, in her official capacity as Commissioner of Social Services of the State of New York, ROBERT ABRAMS, in his official capacity as Attorney General of the State of New York,

Defendants-Appellants-Cross-Appellees,

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, EMPIRE BLUE CROSS AND BLUE SHIELD, HOSPITAL ASSOCIATION OF NEW YORK STATE,

Intervenors-Defendants-Appellants-Cross-Appellees.

Before:

LUMBARD, CARDAMONE, and MCLAUGHLIN,
Circuit Judges.

Appeal and cross-appeal from a judgment of the United States District Court for the Southern District of New

York (Louis J. Freeh, *Judge*), granting plaintiffs' motions for summary judgment in part and denying defendants' motions and cross-motions for summary judgment. The district court held, *inter alia*, that: (1) certain provisions of New York Public Health Law § 2807-c are preempted by ERISA, 29 U.S.C. §§ 1001-1461, and FEHBA, 5 U.S.C. §§ 8901-8914; and (2) ERISA also preempts parts of Actuarial Letter No. 5, issued by New York's Department of Insurance.

Affirmed in part; reversed in part.

M. PATRICIA SMITH, Ass't Attorney General, New York, NY (Robert Abrams, Attorney General of the State of New York, Jane Lauer Barker, Ass't Attorney General in Charge of Labor Bureau, New York, NY, of counsel), *for Defendants-Appellants-Cross-Appellees*.

ROBERT A. BICKS, New York, NY (James J. Sabella, Patricia Anne Kuhn, Breed, Abbott & Morgan, New York, NY; Bartley J. Costello III, Eileen M. Considine, David J. Oakley, Hinman, Straub, Pigors & Manning, P.C., Albany, NY, of counsel), *for Intervenors-Defendants-Appellants-Cross- Appellees Empire Blue Cross & Blue Shield and The New York State Conference of Blue Cross & Blue Shield Plans*.

JEFFREY J. SHERRIN, Albany, NY (Philip Rosenberg, Sherrin & Glasel, Albany,

NY, of counsel), *for Intervenor-Defendant-Appellant-Cross-Appellee Hospital Association of New York State.*

CRAIG P. MURPHY, New York, NY (Darrell M. Joseph, David B. Kostman, Windels, Marx, Davies & Ives, New York, NY; Clifford D. Stromberg, David Hensler, A. Lee Bentley, III, Hogan & Hartson, Washington, DC; David M. Ermer, Brad W. Spencer, Gordon & Barnett, Washington, DC, of counsel), *for Plaintiff-Appellee-Cross-Appellant The Travelers Insurance Company, and Plaintiffs-Appellees Health Insurance Association of America, American Council of Life Insurance, Life Insurance Council of New York, Inc., Mutual of Omaha Insurance Company, The Union Labor Life Insurance Company, Aetna Life Insurance Company and Aetna Health Plans of New York, Inc. and Professional Insurance Agents of New York, Inc. Trust.*

HAROLD N. ISELIN, Albany, NY (Barbara S. Brenner, Steve T. Engelman, Couch, White, Brenner, Howard & Feigenbaum, Albany, NY, of counsel), *for Plaintiffs-Intervenors-Appellees New York State Health Maintenance Organization Conference, Capital District Physicians' Health Plan, Inc., Choicecare Long Island, Inc., Health Services Medical Corporation of Central New York, Inc., Independent Health Association, Inc., Mid-Hudson Health Plan, Inc., Mohawk*

Valley Physicians' Health Plan, Inc., Oxford Health Plans, Inc., Physicians Health Services of New York, Inc., Preferred Care, Inc., Travelers Health Network of New York, Inc., U.S. Healthcare, Inc., and Wellcare of New York, Inc.

Stuart E. Schiffer, Acting Ass't Attorney General, Washington, DC (Roger S. Hayes, U.S. Attorney, Anthony J. Steinmeyer, Scott R. McIntosh, Appellate Staff, Civil Division, Dep't of Justice, Washington, DC, of counsel), *filed a brief on behalf of the United States as Amicus Curiae.*

Susan M. Green, Trial Attorney, U.S. Dep't of Labor, Washington, DC (Judith E. Kramer, Deputy Solicitor of Labor, Marc I. Machiz, Associate Solicitor, Plan Benefits Security Division, Karen L. Handorf, Counsel for Decentralized and Special Litigation, Eric G. Serron, Trial Attorney, U.S. Dep't of Labor, Washington, DC, of counsel), *filed a brief on behalf of the Secretary of Labor as Amicus Curiae.*

Hugh Barber, Ass't Attorney General, Hartford, CT (Richard Blumenthal, Attorney General of the State of Connecticut, Richard J. Lynch, Arnold I. Menchel, Paul J. Lahey, Phyllis E. Hyman, Ass't Attorneys General, Hartford, CT, of counsel), *filed a brief on behalf of the State of Connecticut as Amicus Curiae.*

Benjamin W. Boley, Washington, DC (William H. Dempsey, Shea & Gardner, Washington, DC, of counsel), *filed a brief on behalf of the National Carriers' Conference Committee as Amicus Curiae.*

Edward J. Groarke, Garden City, NY (Colleran, O'Hara & Mills, of counsel), *filed a brief on behalf of Trustees of and The Pension, Hospitalization Benefit Plan of the Electrical Industry and Trustees of and United Food and Commercial Workers Local 174 Health Care Fund, Trustees of and United Food and Commercial Workers Local 174 Retail Welfare Fund, and Trustees of and United Food and Commercial Workers Local 174 Commercial Health Care Fund as Amici Curiae.*

MCLAUGHLIN, *Circuit Judge*:

Defendants Mario Cuomo *et al.* ("the State") and intervenors-defendants New York Conference of Blue Cross and Blue Shield Plans *et al.* appeal from a judgment of the United States District Court for the Southern District of New York (Louis J. Freeh, *Judge*), granting plaintiffs' motions for summary judgment in part and denying defendants' motions and cross-motions for summary judgment. *Travelers Ins. Co. v. Cuomo*, 813 F. Supp. 996 (S.D.N.Y. 1993).

The district court held that certain components of New York's inpatient hospital reimbursement system are pre-

empted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001-1461 (1988 & Supp. IV 1992), and the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. §§ 8901-8914 (1988 & Supp. IV 1992). In particular, the district court invalidated three subsections of New York Public Health Law § 2807-c (McKinney Supp. 1993) imposing surcharges on the hospital rates for certain categories of payors, and not others. The district court also held that ERISA preempts ¶¶ 1, 2, 3, and 5 of Actuarial Letter No. 5, issued by New York's Department of Insurance.

The Travelers Insurance Company ("Travelers") cross-appeals, contending that the district court should also have granted its motion for summary judgment as to ¶ 4 of the Actuarial Letter, as well. We agree with Travelers and reverse that portion of the judgment which held that ¶ 4 is not preempted by ERISA. In all other respects, we affirm.

BACKGROUND

Eighty-eight percent of non-elderly Americans have private health care insurance through their employee welfare benefit plans. ERISA is the governing statute. ERISA plans provide health coverage to employees in various ways, including: (1) the purchase of commercial health insurance from an insurer; (2) self-insurance, whereby the plan is directly responsible for health care bills and usually carries excess liability coverage known as "stop-loss" coverage; (3) subscription to a health maintenance organization ("HMO"); and (4) coverage through non-profit health service corporations, such as Blue Cross/Blue Shield plans (the "Blues").

Any patient entering a hospital is placed in a category known as a diagnosis-related group ("DRG"), based on his symptoms and probable cost of treatment. The amount the hospital may charge for the patient's care is based on the DRG, not the actual cost of treatment. New York law provides that the DRG amount charged to a particular patient is then increased by a "payor factor," depending on the type of health care coverage the patient has. This, of course, results in a "differential" in the charges, depending on which type of health care coverage the patient has.

Since its enactment in 1988, New York Public Health Law § 2807-c(1)(b) has required that insurance carriers of patients covered by any form of health plan other than the Blues, an HMO, or government insurance such as Medicaid must pay 13% above the DRG rate. The 13% differential, which is kept by the hospital, was enacted to contain hospital costs and to increase the availability of hospital insurance coverage to needy New Yorkers. In particular, the differential was meant to " 'level [the] playing field' " for the Blues "in their competition with commercial insurers." Joint Appendix at 649; Clyne Aff. ¶ 15. The hope was that this would encourage more employers and ERISA plans to subscribe to the Blues.

The New York Omnibus Revenue Act of 1992 imposed two more surcharges: (1) an additional 11% surcharge on DRG payment rates charged to patients covered by commercial insurance, 1992 N.Y. Laws, ch. 55, § 348 (codified as amended at N.Y. Pub. Health Law § 2807-c(11)(i) (McKinney Supp. 1993)); and (2) an assessment of up to 9% on HMOs which fail to enroll a target number of Medicaid-eligible persons. 1992 N.Y. Laws, ch. 55, § 346 (codified as amended at N.Y. Pub. Health Law § 2807-c(2-a)(a) (McKinney Supp. 1993)). Unlike the basic 13%

differential, the proceeds of the 11% surcharge are not kept by the hospital, but are paid into a statewide pool, which is then deposited into the State's general fund. HMOs, in contrast, must pay their 9% assessment directly into a statewide HMO pool, but it too ultimately winds up in the State's coffers.

The obvious effect of the 11% surcharge is to increase commercial insurers' costs of providing health care, thus making them less competitive with the Blues. Unlike the 11% surcharge, however, the primary purpose of the 9% assessment is to encourage HMOs to enroll Medicaid recipients, thereby lowering the costs of the Medicaid program.

Besides imposing surcharges, New York's Department of Insurance has issued "Actuarial Information Letter No. 5," regulating how self-insured plans obtain "stop-loss" insurance. The Letter: (1) permits a self-insured to obtain stop-loss insurance only if the plan provides its members with statutorily mandated services; (2) requires that self-insured plans provide beneficiaries with the right to a statutory conversion policy; and (3) requires self-insured plans to afford members various protections in case the plan becomes insolvent.

In separate actions, several commercial insurers and insurance industry trade associations, including Travelers and the Health Insurance Association of America ("HIAA"), sued various New York State authorities for declaratory and injunctive relief, complaining that all three surcharges and the Actuarial Letter are preempted by ERISA, and the 13% and 11% surcharges are also pre-empted by FEHBA. The New York State Conference of Blue Cross and Blue Shield Plans, Empire Blue Cross and Blue Shield (collectively, the "Blues Conference"), and

the Hospital Association of New York State ("HANYS") intervened as defendants; the New York State Health Maintenance Organization Conference and several HMOs intervened as plaintiffs. Thereafter, the parties cross-moved for summary judgment, and the district judge then consolidated the various actions.

The district court granted most of the relief that plaintiffs sought, holding that: (1) the Tax Injunction Act does not preclude an injunction against the 11% and 9% surcharges; (2) ERISA preempts all three surcharges; (3) FEHBA preempts the 13% and 11% surcharges; (4) plaintiffs' claims as to the 13% surcharge are not barred by the doctrine of laches; and (5) ¶¶ 1, 2, 3, and 5 of the Actuarial Letter are also preempted by ERISA. The court enjoined the defendants from enforcing the surcharges and the Actuarial Letter against the appropriate payors, but then stayed its ruling insofar as it enjoined the State from enforcing the 13% surcharge. Defendants appeal and plaintiff Travelers cross-appeals.

DISCUSSION

To promote clarity, we divide our analysis into three segments: (1) whether the district court had jurisdiction over these actions; (2) whether the equitable defense of laches raised by intervenor HANYS has merit; and (3) finally, we address the chief argument advanced in support of reversal, ERISA preemption.

I. *Jurisdiction*

The Tax Injunction Act ("TIA") provides that federal district courts "shall not enjoin, suspend, or restrain the assessment . . . of any tax under State law where a plain,

speedy and efficient remedy may be had in the courts of such State." 28 U.S.C. § 1341 (1988); *see Kraebel v. New York City Dep't of Hous. Preservation & Dev.*, 959 F.2d 395, 400 (2d Cir.) (TIA "bars federal injunctive challenges to state tax laws in federal courts."), *cert. denied*, 113 S. Ct. 326 (1992). This prohibition includes "declaratory as well as injunctive relief." *Barringer v. Griffes*, 964 F.2d 1278, 1280 (2d Cir. 1992).

The district court held that the TIA did not apply to the 11% and 9% surcharges, and therefore, it had jurisdiction. Two conditions must be satisfied to invoke the protection of the TIA: first, the surcharges must constitute "taxes,"[1] and second, the state remedies available to plaintiffs must be "plain, speedy and efficient." *See Kraebel*, 959 F.2d at 400.

A. *Taxes*

The district court "assumed" that the 11% and 9% surcharges were "taxes" under the TIA, stating "to the extent that [these] [s]urcharges are paid into New York's General Fund, they appear to be taxes." 813 F. Supp. at 1000 & n.1 (citation omitted). Although there is no bright line between assessments that are taxes and those that are not, most courts agree that "[a]ssessments which are imposed primarily for revenue-raising purposes are 'taxes,' while levies assessed for regulatory or punitive purposes, even though they may also raise revenues, are generally not 'taxes.' " *Butler v. Maine Supreme Judicial Court*, 767 F. Supp. 17, 19 (D. Me. 1991) (collecting cases). In general, courts "have tended . . . to emphasize the revenue's ultimate use, asking whether it provides a general benefit to

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1 The Blues Conference does not argue that the 13% differential is a "tax" for good reason: its proceeds are retained by the hospitals and not deposited into the State treasury.

the public, of a sort often financed by a general tax, or whether it provides more narrow benefits to regulated companies or defrays the agency's costs of regulation." *San Juan Cellular Tel. Co. v. Public Serv. Comm'n*, 967 F.2d 683, 685 (1st Cir. 1992).

It is apparent that the 11% and 9% surcharges are taxes. Notwithstanding the primary purposes ascribed to the surcharges by the State, both raise revenue which is ultimately paid into the State's general fund. Thus, because the contested surcharges serve general revenue-raising purposes, they constitute "taxes" for purposes of the TIA. *See, e.g., Keleher v. New England Tel. & Tel. Co.*, 947 F.2d 547, 549 (2d Cir. 1991) (the word "tax" under the TIA "encompasses any state or local revenue collection device," including a city-assessed public utility "franchise fee" because the money raised was treated as part of the city's "general revenue"); *Butler*, 767 F. Supp. at 19 (nonrefundable jury fee required in Maine state courts "fits comfortably within [the] definition of a 'tax' under section 1341" because "the fees collected will be funneled into Maine's general fund, rather than being applied directly to the costs of jury trials.").

B. *State Remedy*

The district court found that plaintiffs did not have a "plain, speedy and efficient remedy" in New York state court "[b]ecause ERISA generally confers exclusive jurisdiction on the federal courts." 813 F. Supp. at 1001 (relying upon *National Carriers' Conference Comm. v. Heffernan*, 440 F. Supp. 1280, 1283 (D. Conn. 1977)). Plaintiffs sued here as plan fiduciaries to enjoin a practice violating ERISA. Congress has divested the state courts of jurisdiction over such claims. *See* 29 U.S.C. § 1132(e)(1) (1988); *see also Shofer v. Hack Co.*, 970 F.2d

1316, 1319 (4th Cir. 1992) (where ERISA claims are within the exclusive jurisdiction of the federal courts, state courts are plainly without jurisdiction). Thus, "[b]ecause the [New York] courts lack the jurisdiction to decide the plaintiffs' injunctive and declaratory ERISA claims, the plaintiffs are without a 'plain, speedy and efficient' remedy at state law." *Thiokol Corp. v. Department of Treasury, Revenue Div.*, 987 F.2d 376, 380 (6th Cir. 1993); *accord E-Systems, Inc. v. Pogue*, 929 F.2d 1100, 1102 (5th Cir.) (TIA is "inapplicable" in an ERISA setting), *cert. denied*, 112 S. Ct. 585 (1991).

Accordingly, we conclude that the district court did not err in finding that the state remedies available to plaintiffs were inadequate, and thus it had jurisdiction over plaintiffs' claims.

II. *Laches*

New York's complex reimbursement system has had a differential among various payors since the late 1970s. A statutory differential has existed since 1983. Hence, intervenor HANYS contends that plaintiffs' current challenge to the 13% differential is barred by laches.

Laches is an equitable defense that applies when "a plaintiff unreasonably delayed in initiating an action and a defendant was prejudiced by the delay." *Robins Island Preservation Fund, Inc. v. Southold Dev. Corp.*, 959 F.2d 409, 423 (2d Cir.) (citations omitted), *cert. denied*, 113 S. Ct. 603 (1992). We review a district court's application of the laches doctrine for an abuse of discretion, *see King v. Innovation Books, Div. of Innovative Corp.*, 976 F.2d 824, 832 (2d Cir. 1992), and we find no abuse here.

In our view, there was a legitimate reason for plaintiffs' delay in mounting this challenge. *See Stone v. Williams*, 873 F.2d 620, 624 (2d. Cir.) ("[I]t is the reasonableness of the delay rather than the number of years that elapsed which is the focus of the [laches] inquiry."), *cert. denied*, 493 U.S. 959, *and vacated on other grounds*, 891 F.2d 401 (2d Cir. 1989), *cert. denied*, 496 U.S. 937 (1990). Almost ten years ago, in *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985), we rejected a claim that ERISA preempted New York's regulatory scheme governing hospital rates.

Rebaldo, while probably distinguishable, created little hope for the success of future challenges to New York's reimbursement system. Prospects of success improved only recently because of Supreme Court cases which, as will be discussed *infra*, undermine *Rebaldo*. Immediately after *Rebaldo*, instead of challenging the 13% differential in court, plaintiffs changed their tactics and sought a legislative remedy, instead. Only when these legislative efforts failed in 1992 with the enactment of an additional 11% surcharge did they sue the State. This is not a tableau of unreasonable delay. Accordingly, we find no error in the district court's rejection of the laches defense.

III. *ERISA Preemption*

Whether a particular state statute is preempted by ERISA is a question of statutory interpretation, as informed by congressional intent. With understated irony, the Supreme Court has described the ERISA section at issue here as "not a model of legislative drafting." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985). In truth, it is a veritable Sargasso Sea of obfuscation:

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter *relate to* any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. . . .

(b) Construction and application

. . . .

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which *regulates insurance*, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be *deemed* to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

29 U.S.C. § 1144(a)-(b)(2)(B) (1988) (emphasis added).

The opening paragraph is the *preemption* clause. The next paragraph [(b)(2)(A)] is the *saving* clause. And the final paragraph [(b)(2)(B)] has come to be known as the

deemer clause. *See FMC Corp. v. Holliday*, 498 U.S. 52, 57-58 (1990).

Setting sail, we begin with the observation that ERISA is a comprehensive federal statutory scheme regulating "private employee benefits plans, including both pension and welfare plans." *District of Columbia v. Greater Wash. Bd. of Trade*, 113 S. Ct. 580, 582 (1992). "A 'welfare plan' is defined . . . to include, *inter alia*, any 'plan, fund, or program' maintained for the purpose of providing medical or other health benefits for employees or their beneficiaries 'through the purchase of insurance or otherwise.' " *Id.* (quoting 29 U.S.C. § 1002(1)). While the statute does not mandate particular benefits, it " 'sets various uniform standards, including rules concerning reporting, disclosure, and fiduciary responsibility, for . . . welfare plans.' " *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 137 (1990) (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 91 (1983) (citation omitted)).

ERISA expressly preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by the statute. 29 U.S.C. § 1144(a) (the preemption clause). This sweeping provision is not without qualification and, pertinent to this case, excepts from preemption those state laws that "regulate insurance," 29 U.S.C. § 1144(b)(2)(A) (the saving clause), except as further provided in the deemer clause, stating that an employee benefit plan governed by ERISA shall not be "deemed" an insurance company, an insurer, or "engaged in the business of insurance . . . for purposes of any [state law] purporting to regulate" insurance companies or insurance contracts. 29 U.S.C. § 1144(b)(2)(B); *see FMC Corp.*, 498 U.S. at 58.

The district court concluded that all the surcharges, as well as ¶¶ 1, 2, 3, and 5 of the Actuarial Letter "relate to" employee benefit plans within the meaning of ERISA's preemption clause. The court also found that the surcharges are not preserved by the saving clause as laws that "regulate insurance;" and, without considering whether the Actuarial Letter regulates insurance, the court also concluded that the deemer clause precluded any state regulation of self-funded plans. Accordingly, the district court held that ERISA preempted the three surcharges and also ¶¶ 1, 2, 3, and 5 of the Actuarial Letter. For the reasons set forth below, we substantially agree.

The Supreme Court has "repeatedly stated that a law 'relate[s] to' a covered employee benefit plan for purposes of [the preemption clause] 'if it has a connection with or reference to such a plan.' " *Greater Wash. Bd. of Trade*, 113 S. Ct. at 583 (quoting *Shaw*, 463 U.S. at 97) (citations omitted). The term "relate to" is to be accorded "its broad common-sense meaning," *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47 (1987), thereby giving "effect to the 'deliberately expansive' language chosen by Congress." *Greater Wash. Bd. of Trade*, 113 S. Ct. at 583 (quoting *Pilot Life*, 481 U.S. at 46). "Under this 'broad common-sense meaning,' a state law may 'relate to' a benefit plan, and thereby be pre-empted, even if the law is not specifically designed to affect such plans or the effect is only indirect," *Ingersoll-Rand*, 498 U.S. at 139, and even if the law is "consistent with ERISA's substantive requirements." *Metropolitan Life Ins.*, 471 U.S. at 739. Accordingly, we have held that "a state law of general application, with only an indirect effect on a pension plan, may nevertheless be considered to 'relate to' that plan for preemption purposes." *Smith v. Dunham-Bush, Inc.*, 959 F.2d 6, 9 (2d Cir. 1992).

On the other hand, the Court has also recognized that "[s]ome state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan," *Shaw v. Delta Air Lines, Inc.*, 463 U.S. at 100 n.21 (1983), "as is the case with many laws of general applicability." *Greater Wash. Bd. of Trade*, 113 S. Ct. at 583 n.1. *See, e.g., Mackey v. Lanier Collection Agency & Serv., Inc.* 486 U.S. 825 (1988) (generally applicable garnishment law under which creditors can garnish ERISA welfare benefits not preempted); *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987) (law requiring companies to make lump-sum severance payments when closing a plant not pre-empted); *Aetna Life Ins. Co. v. Borges*, 869 F.2d 142 (2d Cir.) (application of escheat law to ERISA-covered benefit checks and drafts issued but not collected or presented for payment by beneficiaries not preempted), *cert. denied*, 493 U.S. 811 (1989).

On appeal, defendants contend that "the [s]urcharges do not 'relate to' ERISA plans within the meaning of ERISA's preemption clause because they are laws of general application, which have only a peripheral impact on the plans." 813 F. Supp. at 1005. In making this argument, defendants rely on *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985) and fault the district court for its conclusion that *Rebaldo* "has been abrogated by later Supreme Court cases." 813 F. Supp. at 1005.

Rebaldo held that ERISA did not preempt certain New York regulations governing the right of self-insured employee benefit plans to negotiate discounts with hospitals. In rejecting this challenge, we initially found that "a state law must '*purport*[ ] to regulate, . . . the terms and conditions of employee benefit plans' to fall within

the preemption provision" of ERISA. *Rebaldo*, 749 F.2d at 137 (quoting 29 U.S.C. § 1144(c)(2)) (emphasis added). *Rebaldo* went on to hold that the impact of New York's regulations on ERISA benefit plans was too tenuous, remote, and peripheral to require preemption. *Id.* at 138. Six years later, in *Ingersoll-Rand*, 498 U.S. at 141, the Supreme Court expressly rejected the notion that Congress intended to limit ERISA's preemptive effect to state laws *purporting* to regulate plan terms and conditions. *See Smith*, 959 F.2d at 9 & n.3 (following *Ingersoll-Rand*, rejecting "purports to regulate" standard). Despite *Ingersoll-Rand*, defendants continue to argue that *Rebaldo*'s analysis of what triggers ERISA preemption is still controlling.

We have little difficulty agreeing with the district court that *Rebaldo*'s fundamental premise was rejected by the Supreme Court. In our view, *Rebaldo*'s entire analysis is poisoned by its discredited belief that ERISA's preemption clause is targeted only at state laws that "purport to regulate" plan terms and conditions. Therefore, we conclude that defendants' reliance on *Rebaldo* is misplaced.

A. *The Surcharges: Preemption*

Defendants maintain that the district court erred in concluding that the challenged statutes' indirect economic impact upon ERISA plans was substantial and impermissibly affected the structure, the administration, or the type of benefits furnished by a plan. We disagree. While the challenged statutes do not refer to ERISA plans, *see Mackey*, 486 U.S. at 831 (statute need not specifically mention ERISA plans to be preempted), our examination of the surcharges indicates that they satisfy the less stringent "connection with" standard embraced in *Ingersoll-Rand*.

The 13% and 11% surcharges are designed to increase hospital costs for patients covered by health plans other than the Blues, and thus make these competing plans less attractive than the Blues. Obviously, the surcharges will affect ERISA plans' health care benefits. Likewise, the 9% assessment imposed on HMOs will interfere with a plan's selection of the most effective method to provide benefits. Thus, the surcharges purposely interfere with the choices that ERISA plans make for health care coverage. Such interference is sufficient to constitute "connection with" ERISA plans. *See, e.g., National Elevator Indus., Inc. v. Calhoon*, 957 F.2d 1555, 1561 (10th Cir.) (ERISA preempts administrative interpretation of Oklahoma's prevailing wage statute insofar as it determines rates of pay and "may be used to effect change in the administration, structure and benefits of an ERISA plan"), *cert. denied*, 113 S. Ct. 406 (1992); *In re Michigan Carpenters Council Health & Welfare Fund*, 933 F.2d 376, 382-83 (6th Cir.) (ERISA preempts Michigan state corporate reorganization statute that allows employers unilaterally to alter their obligation to ERISA plans), *cert. denied*, 112 S. Ct. 585 (1991); *National Carriers' Conference Comm. v. Heffernan*, 440 F. Supp. 1280 (D. Conn. 1977) (Connecticut tax on ERISA benefits preempted since it may encourage use of traditional insurance rather than ERISA-covered plans); *Morgan Guar. Trust Co. v. Tax Appeals Tribunal of Dep't of Taxation & Finance*, 80 N.Y.2d 44, 51, 587 N.Y.S.2d 252, 256, 599 N.E.2d 656, 660 (1992) (New York real estate gains tax preempted as applied to sale of ERISA property because tax will influence plans' investment strategy).

The surcharges substantially increase the cost to ERISA plans of providing beneficiaries with a given level of health care benefits. Under similar circumstances, the

Fifth Circuit held that a state statute imposing a 2.5% tax on administrative and service fees was preempted by ERISA. *E-Systems, Inc. v. Pogue*, 929 F.2d 1100 (5th Cir.), *cert. denied*, 112 S. Ct. 585 (1991). The court found that the tax was related to ERISA plans because: "The cost of the plan must therefore increase for the employer and/or employees or the benefits must be adjusted downwards to offset the tax bite. This is the type of impact Congress intended to avoid when it enacted the ERISA legislation." *Id.* at 1103.

As in *E-Systems*, the surcharges here force ERISA plans to increase either plan costs or reduce plan benefits. Therefore, they have the requisite connection to ERISA. *See also General Electric Co. v. New York State Dep't of Labor*, 891 F.2d 25, 28 (2d Cir. 1989) (New York Labor Law governing wage requirements was preempted where it required employers to pay certain benefits, because " 'private parties, not the Government, control the level of benefits' " under ERISA) (quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 511 (1981)), *cert. denied*, 496 U.S. 912 (1990); *cf. Arkansas Blue Cross & Blue Shield v. St. Mary's Hosp., Inc.*, 947 F.2d 1341, 1348 (8th Cir. 1991) ("Like all the factors considered, . . . simply because the existence of some economic impact is not dispositive of the preemption issue does not make this factor irrelevant to the preemption inquiry."), *cert. denied*, 112 S. Ct. 2305 (1992).

In making its finding that the surcharges are related to ERISA, the district court focused on plaintiffs' claims that they would pass along the higher costs associated with the surcharges, which might in turn lead plans to reduce their level of service or benefits. Defendants and the Department of Labor as *amicus* contend that the indirect and inevitably speculative economic impact of the challenged

statutes *alone* does not justify a finding of preemption. They argue that the Supreme Court has never held that indirect economic impact, standing alone, is sufficient to justify a finding of preemption. *See, e.g., Mackey*, 486 U.S. at 830-41 (indirect economic effect of state garnishment law not enough to warrant preemption); *see also Aetna Life*, 869 F.2d at 146 ("where a state statute of general application 'does not affect the structure, the administration, or the type of benefits provided by an ERISA plan, the mere fact that the statute has some economic impact on the plan does not require that the statute be invalidated.' " (quoting *Rebaldo*, 749 F.2d at 139)).

The Blues Conference, in particular, relies on *NYSA-ILA Medical & Clinical Servs. Fund v. Axelrod*, No. 92 Civ. 2779 (JSM), 1993 WL 51146, at *4 (S.D.N.Y. Feb. 23, 1993) ("The tax is not great enough to pose a serious economic threat to the plan which might trigger preemption."). There, Judge Martin rejected an ERISA plan's challenge to New York's Health Facility Assessment ("HFA") because its economic impact on the plan was *de minimis*. The court distinguished *Morgan Guaranty Trust*, 80 N.Y.2d 44, 587 N.Y.S.2d 252, 599 N.E.2d 656, on the ground that the New York case involved a "substantial" tax of 10% of the consideration received for the realty sold therein, as opposed to the HFA of 0.6% of gross receipts to which the HFA was applicable. Further, Judge Martin in *NYSA-ILA* explicitly compared the result Judge Freeh reached in this case, with its surcharges of 13%, 11%, and 9% on hospital DRGs. *See NYSA-ILA*, 1993 WL 51146, at *4. Thus, the *NYSA-ILA* court recognized that a *substantial* economic impact, standing alone, could be enough to bring ERISA's preemption clause into play.

In sum, Judge Freeh properly found that the three surcharges "relate to" ERISA because they impose a signif-

icant economic burden on commercial insurers and HMOs. They therefore have an impermissible impact on ERISA plan structure and administration.[2] Accordingly, the statutes at issue here are preempted—unless they are salvaged by ERISA's saving clause as a law that regulates insurance. 29 U.S.C. § 1144(b)(2)(A).

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2 To the extent that our holding conflicts with *United Wire, Metal & Machine Health & Welfare Fund v. Morristown Memorial Hosp.*, 995 F.2d 1179 (3rd Cir. 1993), *petition for cert. filed*, 62 USLW 3061 (July 22, 1993) (No. 93-115), *and petition for cert. filed*, 62 USLW 3114 (Aug. 4, 1993) (No. 93-193), *and petition for cert. filed*, 62 USLW 3114 (Aug. 5, 1993) (No. 93-194), *and petition for cert. filed*, 62 USLW 3144 (Aug. 6, 1993) (No. 93-210), we decline to follow it. In that case, several self-insured union employee welfare benefit plans sued numerous New Jersey hospitals and various New Jersey State authorities for injunctive relief, complaining that New Jersey's statutory scheme for setting hospital rates was preempted by ERISA. The rate-setting statute at issue imposed additional surcharges on DRG rates to compensate hospitals for providing "uncompensated care" and treating Medicare patients, and granted discounts to certain classes of payors.

The Third Circuit held that the rate-setting statute "does not relate to the plans in a way that triggers ERISA's preemption clause." *Id.* at 1191. In brief, the court found that the connection between the statute and ERISA plans was too tenuous and remote "[b]ecause we are here dealing with a statute of general applicability that is designed to establish the prices to be paid for hospital services, which does not single out ERISA plans for special treatment, and which functions without regard to the existence of such plans," *id.* at 1192, and the statute's "indirect ultimate effect of increasing plan costs" places it beyond the scope of ERISA preemption. *Id.* at 1193-95.

Ironically, in reaching its conclusion, the Third Circuit relied heavily on our opinion in *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985). As we discuss above, however, we believe that decisions of the Supreme Court since *Rebaldo* have significantly eroded the premise upon which *Rebaldo* was decided. More generally, however, we also believe that the Third Circuit reads ERISA's preemption clause too narrowly. *See United Wire*, 995 F.2d at 1196-1203 (Nygaard, J., dissenting).

B. *The Surcharges: Saving Clause*

To determine whether a state law regulates insurance within the meaning of the saving clause, a court must first "consider the 'common-sense view' of the term 'regulates insurance' which suggests that 'in order to regulate insurance, a law must not just have an impact on the insurance industry, but must be *specifically* directed toward that industry.'" *Howard v. Gleason Corp.*, 901 F.2d 1154, 1158 (2d Cir. 1990) (quoting *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50 (1987)). The court must next assess whether the law satisfies the three criteria developed for determining whether a practice constitutes "the business of insurance" within the meaning of the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015 (1988 & Supp. IV 1992).[3] *See Pilot Life*, 481 U.S. at 48. Those criteria are: " '*First*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry.' " *Id.* at 48-49 (quoting *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982)).

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3 The McCarran Act was enacted in 1945 to help resolve federalism concerns over the roles of federal and state governments in regulating insurance. Now known as the McCarran-Ferguson Act, it provides, in relevant part:

> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided*, That [the Sherman Act, the Clayton Act, and the Federal Trade Commission Act] shall be applicable to the business of insurance to the extent that such business is not regulated by State Law.

15 U.S.C. § 1012(b).

Applying these tests, we conclude, first of all, that the 13% and 11% surcharges do not "regulate insurance" within the meaning of the saving clause.[4] Our common-sense inquiry reveals that these surcharges are not specifically directed toward the insurance industry; rather, they aim to regulate hospital rates. Although the surcharge laws provide for different payment rates based on whether a patient is uninsured, covered by an HMO, a commercial insurer or a self-insured health plan, they do not address matters typically within the purview of state insurance regulations such as: the solvency and qualification of an insurance company's management, the sale and advertising of insurance, rates and the content of insurance policies. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 727-28 & n.2 (1985).

Defendants argue that the 13% and 11% surcharges are designed to affect the insurance marketplace by giving the

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4 The Department of Labor ("DOL") argues that the saving clause validates all three surcharges; the Blues Conference argues that it preserves the 13% and 11% surcharges; and the State invokes it only as to the 11% surcharge. Although both the DOL and the Conference claim that HMOs are insurers for purposes of the saving clause, only the DOL contends that the 9% assessment on HMOs comes within ERISA's saving clause. The DOL argues that HMOs are engaged in the "business of insurance" when they reimburse hospitals for providing services to their subscribers. While HMOs must comply with certain provisions of the insurance law by virtue of the public health law, *see, e.g.*, N.Y. Pub. Health Law §§ 4402(2)(f) and 4406(1) (McKinney 1985) (superintendent of insurance required to review HMO subscriber contracts); N.Y. Pub. Health Law § 4409(2) (McKinney 1985) (superintendent required to examine each HMO's financial affairs periodically), New York law does not require HMOs to be state-licensed insurers. N.Y. Ins. Law § 1109(a) (McKinney 1985 & Supp. 1993). Nor can HMOs include in their names "words generally regarded as descriptive of the insurance function." N.Y. Pub. Health Law § 4411 (McKinney 1985). These latter provisions support the district court's finding that the 9% assessment does not "fall within the scope of the savings clause because HMOs . . . do not engage in the 'business of insurance' as a matter of law." 813 F. Supp. at 1007.

Blues a competitive advantage over commercial insurers, self-insured funds, and a number of other players in the marketplace—and thus may be characterized as the regulation of insurance. This argument, however, confuses laws regulating the "business of insurance" with laws regulating hospital rates that have an effect on the "insurance marketplace." Although the surcharge laws clearly have some impact on insurance companies, this alone is not enough. As the Supreme Court has made clear in interpreting § 2(b) of the McCarran-Ferguson Act, there is a difference between the "business of insurance" and the "business of insurers." *See Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 210-17 (1979).

In our view, defendants' arguments proceed from an impermissibly broad reading of the saving clause. Congress intended that ERISA's preemption provision would clear the field of any state law interfering with benefit plans, *see, e.g., FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990); *Pilot Life*, 481 U.S. at 47-48, and installed the saving clause to preserve only those state laws precisely directed at the insurance business. The more expansively the saving clause is read, the more deeply it cuts into the preemption, a result that would render the entire scheme unworkable.

Nor do the McCarran-Ferguson factors suggest otherwise. The Blues—unlike commercial carriers—offer health insurance to anybody, no matter who they are or what physical shape they are in. As the insurer of last resort, the Blues insure persons and groups that are, on the whole, older and less healthy, and therefore constitute unacceptably high risks for other insurers. Most high risk policyholders, therefore, are insured under the Blues. Because the 13% and 11% surcharges are designed to encourage ERISA plans—with generally healthier per-

sons—to shift to the Blues, the State's reimbursement system would help spread the risk of health care costs.

Group Life & Health Insurance Co. v. Royal Drug Co., 440 U.S. 205 (1979), does not alter this conclusion. There, the Supreme Court ruled that Blue Shield's arrangement with certain pharmacies to charge Blue Shield's insureds only $2 for every prescription drug did not constitute the "business of insurance" under McCarran-Ferguson. As noted by the district court here, "[t]he Supreme Court held that the agreements between Blue Shield and the participating pharmacies did not spread any risk because those agreements merely reduced Blue Shield's costs for fulfilling an obligation which Blue Shield had already assumed." 813 F. Supp. at 1008 n.15 (citing *Royal Drug*, 440 U.S. at 212-14). Here, the challenged surcharges do not merely raise the cost of inpatient hospital services, but play a significant role in encouraging ERISA plans to shift to the Blues. Thus, unlike *Royal Drug*, the surcharges here can be said to have "the effect of transferring or spreading a policyholder's risk." *Pilot Life*, 481 U.S. at 48 (quoting *Union Labor Life Ins.*, 458 U.S. at 129).

The 13% and 11% surcharges, however, fail to satisfy the remaining two McCarran-Ferguson factors. These surcharges do not regulate any practice that is integral to the insurer-insured relationship. As we noted on an earlier occasion, the essence of the second McCarran-Ferguson factor is whether a statute "dictate[s] any of the terms of the insurance contract itself, the principal embodiment of the insurer-insured relationship." *Howard*, 901 F.2d at 1159. True, the surcharges here were designed to induce ERISA plans to switch their hospital coverage from commercial insurers to the Blues; but they do not directly change any of the terms, conditions or scope of coverage

in commercial insurance contracts. Rather, because the surcharges expressly regulate hospital rates, they relate only to the contractual obligations between hospitals and insurers or insureds, but do not directly implicate the policy relationship between insurers and their insureds.

Finally, the surcharges are not "limited to entities within the insurance industry." *Pilot Life*, 481 U.S. at 49 (quoting *Union Labor Life Ins.*, 458 U.S. at 129). In *Howard*, a provision of the New York Insurance Law required that either the insurer or the employer (in certain circumstances) give notice of conversion privileges upon termination of employment. *Id.* at 1156. We found that this provision was not a regulation of insurance. *Id.* at 1159. We noted that since the notice could be given by either the employer or the insurer, the law was not limited to entities within the insurance industry. *Id.* Here, the surcharges set rates that hospitals must charge patients, and thus involve entities beyond the insurance industry, including: the State, hospitals, patients, HMOs, and self-insured funds. Thus, the third McCarron-Ferguson factor is not satisfied.

Accordingly, because of our common-sense determination that the surcharges do not regulate insurance, and because two of the three McCarran-Ferguson factors are not satisfied, we agree with the district court that the 13% and 11% surcharges are not preserved by the saving clause. Accordingly, the New York statutes imposing the surcharges are preempted by ERISA.[5]

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5 We also agree with the district court that the 9% assessment does not "fall within the scope of the savings clause because HMOs . . . do not engage in the 'business of insurance' as a matter of law," 813 F. Supp. at 1007, and is thus preempted by ERISA. *See* discussion *supra* note 4.

Because we hold that ERISA preempts the three surcharges, we need not reach the issue whether the 13% and 11% surcharges are also preempted by FEHBA.

C. The Actuarial Letter

Self-insured employee benefit plans and their employer sponsors, including the Sheridan Catheter Plan (on whose behalf Travelers challenges the Actuarial Letter), often purchase stop-loss insurance to protect themselves against excess or catastrophic losses. Unlike traditional group-health insurance, stop-loss insurance is akin to reinsurance in that it does not provide coverage directly to plan members or beneficiaries. Rather, most stop-loss policies (and the policy issued to the Sheridan Catheter Plan here) provide coverage to the plan itself if the total amount of claims paid by the plan exceeds the amount of anticipated claims by a specified sum.

The Actuarial Letter under attack purports to regulate the terms of such stop-loss insurance contracts. Its relevant provisions follow:

1. The insurer must undertake to ensure that statutorily mandated benefits be covered under the employer's plan;

2. The insurer must agree to ensure that statutory conversion policies be provided, either by them or by another insurer;

3. Notice must be given to employees if and when the insurer becomes liable for runoff claims. . . .

4. The insurer should maintain full runoff reserves. If the policyholder holds his own reserves, the insurer's claim reserves are to be replaced by a terminal premium payable immediately upon termination. . . .

5. The insurer must take full responsibility for the payment of all employer plan claims incurred but

not yet paid at the date of termination of the policy . . .

The district court properly found that ¶¶ 1, 2, 3, and 5 of the Actuarial Letter "relate to" an employee benefit plan for purposes of ERISA's preemption clause. Paragraphs 1 and 5 on their face make specific "reference to" an employee benefit plan, and ¶¶ 2 and 3 clearly have a "connection with" such plans. *See Greater Wash. Bd. of Trade*, 113 S. Ct. at 583 (quoting *Shaw*, 463 U.S. at 97). ERISA therefore preempts ¶¶ 1, 2, 3, and 5 of the Actuarial Letter unless they find salvation in ERISA's saving clause as a law that regulates insurance, and even that salvation will be denied unless the employee benefit plan can escape the orbit of § 1144(b)(2)(B) refusing to deem such a plan "to be an insurance company or other insurer."

The district court concluded that ¶¶ 1, 2, 3, and 5 were preempted and the saving clause for insurance regulations did not save them because, under the deemer clause, self-insured employee benefit plans are not deemed to be "an insurance company or other insurer . . . ." *FMC Corp. v. Holliday*, 498 U.S 52, 61 (1990). The Department of Labor and Travelers, while agreeing with this result, suggest that the district court should not have reached the deemer clause without first considering whether ¶¶ 1, 2, 3, and 5 regulate insurance at all, within the meaning of the saving clause. We agree. Accordingly, we affirm the district court's holding on a different ground: ¶¶ 1, 2, 3, and 5 are not saved from preemption because those paragraphs do not regulate insurance within the meaning of the saving clause.

As already discussed, in order to fall within the saving clause, the state law must constitute the regulation of insurance from a common-sense point of view and must

also satisfy the McCarran-Ferguson factors. *See Pilot Life*, 481 U.S. at 48-49. The challenged provisions of the Actuarial Letter do neither.

Pilot Life's common-sense test does not validate every conceivable restriction on the sale of insurance contracts under the rubric of regulation of insurance. *See Howard*, 901 F.2d at 1158. We conclude that ¶¶ 1, 2, 3, and 5 of the Actuarial Letter use the regulation of stop-loss coverage as a pretext to regulate the terms of self-funded ERISA plans.

In ¶ 1 of the Actuarial Letter, the State permits a self-insured plan to obtain stop-loss coverage only if the plan provides its members and beneficiaries with the full panoply of benefits mandated by New York's Insurance Law. Paragraph 2 requires the plan to provide its beneficiaries with the right to a statutory conversion policy. Paragraphs 3 and 5 require the plan to afford its members a host of protections in case the plan becomes insolvent. Because the conditions imposed by the Actuarial Letter are not limited just to the stop-loss layer of insurance but apply generally to the entire plan, we conclude that ¶¶ 1, 2, 3, and 5 of the Letter do not, as a practical matter, regulate just insurance.

Furthermore, the challenged provisions of the Actuarial Letter do not satisfy the McCarran-Ferguson criteria. First of all, ¶¶ 1, 2, 3, and 5 do not have the effect of transferring or spreading risk between a self-funded plan and its stop-loss insurer but, instead, require the self-insured plan to provide additional benefits and protections to the plan's members and beneficiaries.

Second, the challenged provisions are not an integral part of a self-funded plan's relationship with its stop-loss insurer. Paragraph 1, for example, focuses squarely on the

self-funded plan's relationship with its participants, not with the stop-loss insurer. Because employees are not insured under the terms of the stop-loss policy, requiring the stop-loss insurer to notify such individuals, as ¶ 3 does, is not an integral part of the insurance relationship. Likewise, because ¶ 5's purpose is to protect employees, who are not insured under the stop-loss contract, that paragraph is not an integral part of the insurance relationship between the plan and its stop-loss insurer.

Finally, ¶¶ 1, 2, 3, and 5 are not limited to insurance entities. Paragraph 1 is aimed directly at sponsors of self-funded plans. By requiring the sponsoring employer to provide conversion rights through another insurer if the stop-loss insurer does not provide such rights, ¶ 2 is aimed directly at employers who are not part of the insurance industry. *See Howard*, 901 F.2d at 1159 (state law requiring either insurer or employer to notify covered employees of conversion rights was not "limited to entities within the insurance industry"). Likewise, ¶ 3 states specifically that the Department of Insurance "will accept a policy provision which requires the employer to pass along [the notice] material." Thus, it too is not "limited to entities within the insurance industry." *See id.*

In sum, the challenged provisions of the Actuarial Letter satisfy neither the common-sense test nor the McCarran-Ferguson factors. Consequently, they do not fall within the saving clause and are preempted.

The district court also held that ¶¶ 4, 6, and 7 of the Actuarial Letter do not "relate to" ERISA plans and, accordingly, did not reach the saving clause argument as to those paragraphs. On cross-appeal, Travelers argues that the district court erred to the extent it found that ¶ 4

does not "relate to" ERISA plans.[6] We agree and therefore reverse that part of the district court's decision holding that ¶ 4 is not preempted.

Paragraph 4, like ¶¶ 1, 2, 3, and 5 of the Actuarial Letter, is directed at the purchasers of stop-loss coverage which are primarily ERISA plans. It effectively requires the "policyholder"—which is an ERISA plan—either to purchase insurance for "run-off claims" or maintain significant reserves of its own. This alone merits a finding that ¶ 4 has a "connection with" employee benefit plans and, therefore, is "relate[d] to" such plans for purposes of ERISA's preemption clause because stop-loss protection will guarantee that benefits are paid to employees even if the carrier suffers catastrophic losses.

Reaching the saving clause argument, we conclude that ¶ 4 does not "regulate insurance" and therefore is not saved from ERISA preemption. In our view, ¶ 4 attempts to regulate, through the self-loss insurer, the benefits offered by and the administrative functioning of self-funded ERISA plans. Paragraph 4 is similar to the other challenged paragraphs. Like ¶¶ 1, 2, 3, and 5 of the Actuarial Letter, ¶ 4 does not fall within the saving clause and is, therefore, preempted.

We hold, therefore, that the five challenged paragraphs do not regulate insurance within the meaning of the saving clause and, accordingly, are preempted. We affirm the district court's ruling as to ¶¶ 1, 2, 3, and 5 of the Actuarial Letter, and reverse as to ¶ 4.

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6 The district court's findings as to ¶¶ 6 and 7 are not now challenged by Travelers or the Department of Labor.

CONCLUSION

To sum up: We find that the district court properly found that plaintiffs' challenges to the 11% and 9% surcharges are not barred by the TIA. Nor is their challenge to the 13% differential barred by laches. Further, the district court properly held that the three surcharges are preempted by ERISA. Finally, we affirm the court's decision as to ¶¶ 1, 2, 3, and 5 of the Actuarial Letter, and reverse as to ¶ 4.

Accordingly, the judgment of the district court is affirmed in part, reversed in part, and the district court is directed to enter judgment consistent with this opinion.